The experience of bariatric or weight-loss surgery (WLS) - with particular reference to changes in the relationship with food.

Submitted by Janet Elizabeth Moreland to the University of Exeter as a thesis for the degree of Doctor of Clinical Practice

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I confirm that all names and identifying information has been changed to protect confidentiality.

Signed..

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In memory of my mother who, at the age of eighty-seven upon going blind, taught herself to read Braille.

Abstract

> The ancient prescription of Hippocrates (400 BC) that the obese should 'eat less and exercise more' is still today, and for the foreseeable future, the cornerstone approach to treat obesity despite its well-documented failures. (Dulloo, 2012 p1418)

There is considerable research into bariatric surgery as a treatment for the purposes of weight-loss and reduction of co-morbidities associated with obesity, but very little of it is written from the patient's point of view. This study is a contribution towards remedying that lack.

Twenty participants, who were both pre- and post-surgery, were recruited from self-help support groups and asked to talk about their experience of WLS. A critical narrative-discursive approach is used to analyse the transcriptions of the interviews informed by my experience as a reflexively practising psychoanalytic clinician.

Participant's identity construction is explored with regard to the discourses chosen to account for their weight which enabled them to avoid being stigmatised as morally failing to fulfil the neo-liberal task of personal responsibility for their health. The concept of positioning over time is used to demonstrate the shift from being blameless for their past size, to one of being blameworthy were they to put on weight post-surgery. This facilitated a fattist discourse when those who *had* regained weight after WLS were othered as failing to use the 'tool' of WLS, which in turn made it necessary to locate control, or to account for the lack of it. It was expected that participants would express feelings of loss with regard to food, and some disturbance in their experience of their rapidly shrinking bodies, but neither manifested significantly.

Key words: WLS; bariatric surgery; patient experience; obesity; narrative-discourse analysis; DA; reflexivity.

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Abbreviations, Acronyms and Definitions

APPGO = All-Party Parliamentary Group on Obesity

BMI = Body Mass Index which is calculated by dividing the weight in kilograms by the height in meters squared.

DA = Discourse Analysis

HSCIC = Health and Social Care Information Centre

LAGB = Laparoscopic Adjustable Gastric Band

LRD = Liver Reducing Diet
The LRD is a very strict diet intended to shrink the liver so that surgery is made possible.

NICE or **NIHCE** = National Institute for Clinical Excellence or the National Institute for Health and Clinical Excellence

NHS = National Health Service

PHE = Public Health England

PDP = Psychoanalytic Discursive Psychology

WLS = Weight Loss Surgery

Chapter One: Introduction

1:1 At the Beginning

Bariatric surgery, as a treatment for the purposes of weight-loss and reduction of co-morbidities associated with obesity, is a tool recommended for use in dealing with the 'obesity crisis' which currently occupies much governmental, medical, and media attention. There is considerable research into weight-loss surgery (WLS), but relatively little is written about what it is like for those who undergo it. Through a Discourse Analysis (DA) of conversations with twenty WLS candidates the aims of this dissertation were:

- To analyse interviewees' accounts of their experiences in relation to the discourses available in the culture.
- To gain an understanding of any changes in the participant's relationship to food after surgery.

1:2 My Approach

The construction of identities, those of the participants and my own, has run as an undercurrent throughout this research, informing the choice of subject, the way of finding interviewees, the method of analysis, and the style in which I have written. The people I talked with generously offered themselves and their stories, trusting that I would not abuse what I was given and risking exposing themselves to scrutiny. In the light of this it seemed only reasonable that I should, self-consciously, take a similar risk. We all expose ourselves when we write, even if we try to hide behind formal academic discourses, but I intend to do it more explicitly. So, I have frequently used the first person singular with the aim of demonstrating how my experience has informed my thinking, methods, and conclusions.

1:3 ***"…a truth universally acknowledged…"*** Jane Austen

In order to discuss WLS, I will first describe the surgery itself and then consider a situation in which it is thought appropriate and cost-effective to take measures which surgically alter a person's healthy digestive system in an irreversible fashion, thereby leaving them susceptible to possible side-effects which I describe below.

The Surgery

1:3:1 The number of people undergoing bariatric surgery as the most effective treatment currently available for morbid obesity is rising substantially. Sjöström (2013) argued that, in the majority of patients, surgery produces sufficient weight-loss and reduction in the common co-morbidities of obesity for the continued use of an expensive and drastic solution to be considered justified. Depending upon the type performed, WLS results in irreversible change to the body and its functioning. Like all forms of surgery, it is not without risk both in the sense of not always achieving its aims, i.e. weight-loss and reduction in co-morbidities, but also the risks common to all major abdominal procedures such as complications due to being anaesthetised, control of bleeding, infections, cardiovascular problems, and hernias.

(i) The laparoscopic adjustable gastric band (LAGB) is inserted to create a small pouch from the upper part of the stomach. The band is filled via a port with saline solution to restrict the amount of food that can be ingested. Between 1% (Hutter,et al2011) and 5% (Burton,et al2011) of people having the LAGB will require further hospital treatment to deal with erosion, band slippage, pouch dilation, and problems with the port (Radcliffe2013). Three of my participants had a band fitted – a further prospective interviewee had to return to hospital to correct a problem at the time we were due to meet.

(ii) The sleeve gastrectomy involves dividing the stomach vertically using staples, and the redundant portion of stomach is removed. Problems include leakage from the staple-line or actual rupture of the staples, infection, bleeding, and pulmonary embolism (Radcliffe2013). Up to 5% of patients need hospital treatment to correct any problems (Hutter,et al2011). Three of my interviewees

had sleeves fitted, one with life-threatening complications, the others had no problems specifically related to the surgery.

(iii) The majority of participants had a Roux-en-Y gastric bypass (RYGB) in which the stomach is stapled to create a small pouch and the remainder is cut away. The small intestine is cut and joined to the pouch, and the remaining piece of intestine which is still attached to what is left of the stomach, is reattached to the small intestine at a lower point. In the long-term, up to 25% of these patients will have major complications such as strictures of the joins potentially causing complete obstruction, ulceration of the stomach, internal hernias and abdominal pain. (Radcliffe2013)

In addition to the surgical problems, patients have to be prepared for other side-effects of WLS. One of the commonest with RYGB is 'dumping', the symptoms of which "…include irregular heartbeat, drop in blood-pressure, diarrhoea, and nausea. According to recent studies, such symptoms are due to a series of physiological processes that are triggered when food reaches the small intestine too quickly... Moreover, rapid delivery of carbohydrates to the small intestine is reported to cause excessive insulin secretion. Whether these processes cause 'dumping' symptoms – or are a consequence of it – is, however, still a matter of controversy..." (Groven,et al2012p37). Dumping is often viewed in a positive light because it functions as a deterrent to over-eating. For example Radcliffe says "…bariatric surgeons and dieticians view it as a useful learning experience, training patients not to consume sugary, high calorie foods." (2013p176). RYGB can produce a loss of appetite which is mostly short-term – this also tends to be viewed as a positive effect (Cranwell&Seymour-Smith2012), although in the long term it can be problematic. Other side-effects are vitamin and mineral deficiencies which require regular injections to correct them; hair-loss; weakening of the nails; osteoporosis; gall-stones; oesophageal reflux which can lead to ulceration and spasms which mimic cardiac pain. (Murray2009) Vomiting is another feature of all forms of WLS because of the limited amount of food that can be contained in the stomach pouch. (Mitchell,et al2001)

Most WLS patients experience considerable changes in their ability to eat, not just in terms of the amount it is possible to consume, but also in the types of food they can tolerate. One fortunate, but not universal, outcome of the surgery is that high sugar food and drink are no longer desired (Rao2012) in the sense that they are no longer palatable or become difficult to tolerate (Pepino2014). This is not always the case - some people find that these are the foods which are most easily digested. (Ogden,et al2006) There appear to be no comprehensive rules as to what can or cannot be consumed. Some can eat almost anything from their pre-surgery diet, whereas others have to find out by trial and error what it is possible to eat – and for some that varies from day to day. The experience of taste and texture can change after WLS so that foods once disliked become desirable and vice versa. Patients are advised to adopt a strict pattern of eating after surgery, initially consuming only liquids, progressively introducing pureed and then mashed foods. Finally after some weeks, solid foods can be introduced. Meals must be consumed according to strict rules of numbers of 'chews', gaps between mouthfuls, and to be of limited duration. No liquids should be consumed within half an hour of eating. (PIL,2013,Appendix 1) This is not conventional eating, but needs to be adhered to in order to avoid painful repercussions and requires a high level of discipline and self-control. (Natvik,et al2014)

There is a significant proportion of those operated upon, from 20-30% (Livhits et al2012), for whom WLS does not produce the desired effects of weight-loss and/or co-morbidity reduction. A great deal of research effort has been put into discovering whether it is possible to predict who will or will not be able to benefit from the surgery – with no clear predictors being found (Griauzde,et al 2018;Livhits et al2012;Moroshko,et al2012;Wolfe&Terry2006). Relatively little attention has been paid to the detail of patient expectation and experience of surgery except insofar as it can predict outcome (Foster,et al2001) – although this is a situation which has begun to change recently. (Groven,et al2015; Groven & Glenn2016;Jackson,et al2017;Jumbe&Meyrick2018;Knutsen&Foss2011;Knuts-en,et al2011b;Knutsen,et al2013;Natvik,et al2018)

The 'War on Obesity'

1:3:2 Since 1991, when the government "…formally recognized that obesity was a sufficient threat to the health of the nation to warrant specific action. " (Jebb,et al2013p42), it has been a significant aspect of health policy to give prominence to and collect data[1] about the increase in the incidence of obesity and the health problems associated with it. In 2003 the APPGO reported on "…the roles of the food industry and the commercial weight loss sector in tackling obesity, as well as obesity in children…(they also looked) at different aspects of the medical management of obesity,…(and) examine(d) the behavioural and psychological aspects to tackling obesity and severe overweight successfully." (2003p2).

This report covered a wide range of possible causes of obesity such as increased availability of cheap, energy-dense food, changes in life-style and work patterns. Being born into an economically deprived situation was only reported as increasing the likelihood of children becoming obese. The association of stress with overweight was not taken into account. (Bose,et al2009;Dallman,et al 2005; Epel2001;Sinha&Jastreboff2013). Over time this blindness to the role of factors such as stress and poverty in the incidence of obesity became even clearer. In 2011, *Healthy Lives Healthy People* stressed the role of overconsumption, and emphasised the importance of decreasing energy-intake and raising physical activity, thus firmly placing responsibility for weight upon the individual. Yet Public Health England was publishing factsheets which demonstrated that "(o)verall, for women, obesity prevalence increases with increasing levels of deprivation, regardless of the measure used. For men, only occupation-based and qualification-based measures show differences in obesity rates by levels of deprivation." (PHE 2014p1). Probyn says, "In terms of weight, obesity and eating practices, there is no possible way of understanding the phenomenon and problematic without centrally focusing on social class." (2009p114) and, as Boero puts it, "(t)he obesity epidemic is replete with examples of fat bodies absorbing much of the criticism that might otherwise be levelled at structural inequality." (2012p101). This suggests that it is politically expedient to place responsibility onto the individual for what is a complex problem.

It is difficult to ignore the element of moral panic (Boero2013;Campos,et al2005; Rigby2006) when phrases like 'obesity epidemic' or 'the war on obesity' are used in the media and a Chief Medical Officer refers to increases in average BMI as a "time bomb" (Jebb,et al 2013p42). Predictions were made in 2007 that:

- " By 2025, 47% of men and 36% of women (aged between 21 and 60) will be obese.
- By 2050, it is estimated that 60% of males and 50% of females could be obese.

More recent modelling suggests that:

- By 2030, 41% to 48% of men and 35% to 43% of women could be obese if trends continue." (HSCIC,2015,Section2.8)

The present rates are 26% for men and 24% for women, and the rate of increase has been slowing in recent years yet the language used suggests that there is an inexorable rise which must be stemmed. Monaghan says, "…the actual extent of risks and deaths assumed to be due to fatness is scientifically indeterminable and, like any currency, subject to potentially massive inflation. Furthermore, population risks do not translate to individual risks…" (2005p304)

1:4 A Solution?

My choice of subject for this thesis was influenced by this climate in which we are told that an 'obesity epidemic' is threatening the survival of the NHS. The anti-fat discourse makes the choice of surgery as a solution to extreme weight appear reasonable despite the dangers attendant upon major surgery. There are also the risks specific to WLS such as malnourishment unless a strict regime of diet and vitamin intake is followed for the rest of the individual's life. "…(T)he gastric bypass procedure is an operation that alters irreversibly the anatomy and physiology of a healthy stomach, whereas the individual's eating habits cannot be situated in or reduced to a particular organ, but are endemic to the lived body..." (Groven,et al2012p36). This appears to be an assault upon the fat body, a criticism of those who demonstrably make themselves conspicuous, who show their refusal to accommodate themselves to the prevailing standards of 'healthy'

living, and are thereby accused of being a cost to the rest of society through their increased demand for health care. The fat body is mute witness to over-consumption - in a society which depends for its economic survival upon us all consuming more than we need (Bordo2003) - and is then criticised for taking more than its fair share of scarce resources. (Rigby2006)

1:5 Intersections of Culture and the Individual

In this next section I give an account of the style in which this paper is written. I am a psychoanalytic clinician, and have personal, political, and professional interests in my chosen research area. I do not pretend to a disinterested objectivity, but that should not interfere with a transparent presentation of my findings. I am aware that this is a difficult position to take, and note Wall's caution that "…there can be a number of pitfalls…that can threaten the scientific merit of a study: these include seeing only what serves the researcher's purposes, placing passion before science, making claims beyond the evidence and replacing reason with stridency." (2006p44). I did not find the answers I expected and gained a much fuller and more nuanced perspective on WLS than the one with which I began. It is also uncomfortable for me in the way described by a number of authors who write from feminist positions (Boero2012; Donaghue&Clemitshaw2012;Longhurst2005;Murray2009;Parsons2013;Throsby 2012b;Throsby&Gimlin2010) because there is a paradox in that, while I object to the pressure on women in particular to police their bodies, I am a member of this culture and (unwillingly) subscribe to that policing of my own body.

After many false starts and endless questioning about what story I wanted to tell and how to tell it, I asked myself what prompted *this* particular choice of subject? My first answers were very personal and I wondered how I could include that part of the story in a way which would be considered sufficiently 'academic'. Others have also searched for a way of writing which would not only allow for, but actively take into account my self-scrutiny and reflection on my bodily experience of living in this culture at this time and regard those as having a significant influence on the nature and quality of my research. (Coffey2002;Den-

shire2013;Dyson2007;Ellingson2006;Richards2008;Wall2006). "What needs to be known about the researcher in order to evaluate the research and how can this be known?" (Parsons2013p13). It was a matter of making myself visible in the writing (Anderson2006) while trying not to "romanticiz(e) the self" (Atkinson&Silverman1997).

As a psychoanalytic clinician it seemed obvious that I would reflect upon my motivations and responses to the material I collected given that that is what I do in my clinical work – and not in the token fashion where being reflexive is illustrated by "…a paragraph in an otherwise neutral and objectively presented manuscript." (Wall2006p3). My understanding of myself is offered so that readers can have some of the information necessary to evaluate the quality of my research. But also, as a member of the wider community of women who are constantly aware of their size, I will be writing as an insider to this struggle. This felt important, not because I thought it would give me privileged access to truth, but because I had been concerned that I could be seen as gawping at a freak show (Rice2009), at people who have been 'othered' by a culture in which fat is stigmatised. (Chase&Walker2012;Johnson,et al2004;Lister2015)

My own experience was a motivating factor for this research, but to write personally is to lay oneself open to criticism for navel-gazing, while disembodied writing conveys the appearance that one is producing objective, abstract, categorical knowledge. (Dyson2007). To acknowledge the personal, embodied nature of my work was appropriate to a topic of such obvious physicality as WLS – something that is argued to be lacking in much health research where the researcher's person, body and mind, is treated as unproblematic. (Coffey2002; Denshire2013;Richards2008) There is a particular irony in leaving out the body of the author when one is focusing upon the stigmatised bodies of others. Ellingson says that "…the definition of researchers' bodies as absent and inconsequential upholds their power over their participants." (2006p300). She adds that "(i)t is the privilege of the powerful to leave their bodies unmarked…today it is the privilege of being unmarked, of having one's positionality obscured as the norm, that signifies power." (ibid,p301) in the same

way that whiteness is treated as the norm so that bodies of colour are marked as deviant. (Frankenberg2009)

So I have chosen to write about my own bodily experience because it was the prompt for this research, but also because it is a way in which "…to acknowledge the inextricable link between the personal and the cultural…" (Wall2006p1). Since early puberty I have been preoccupied to varying degrees with the *feeling* of being fat. I am not, and never have been obese, but I have rarely *felt* anything other than fat. I know I am not fat, in fact I am on the slim side of what is medically considered a healthy weight, yet I can *feel* fat. Associated with this has been a preoccupation with food and its meaning in my life and I wondered what I would do if I was physically restricted by WLS in such a way that I could no longer eat as I do now. This research and the reading which has accompanied it, has made me think and re-think my experience of my weight and how I view that of others.

My second answer to the question of why *this* topic was also very personal and rooted in my anger at the way in which I, and countless other women in this culture, have been affected by the pressure to be unhealthily thin. In a century we have gone from a situation in which Edwardian women were only considered beautiful if they had dimpled arms and their décolletage showed none of its bony substructure, to the present where cat-walks are peopled by anorexic waifs, and celebrities are mocked and chastised for the slightest sign of fleshiness. This change has coincided with rising incomes and a lowering in the relative cost of food, so that where plumpness was once a sign of wealth, and being 'stout' meant both fleshy and healthy, it is now achievable by most people in industrialised countries. Now privilege is marked by adherence to the current standards of a 'healthy' weight as recommended in government guidelines and these are presented as the norm so that those who fail to adhere to them are seen as aberrant and deserving of criticism. I am aware of the contradictions in which I am caught – as a member of this culture I have absorbed its values and judge myself and others by them yet I am discomfited by the abuse of power involved.

The third answer was even less comfortable to acknowledge because it meant admitting to some kind of evangelical zealotry in the form of a desire to 'cure' or 'rescue' the victims of overweight. It was a fantasy that because *I* had found a way to manage my own weight without physical discomfort, in other words without feeling physically hungry or deprived, I wanted to take my message out to 'convert the heathen'. This falls into the realm of the story of transformation or "rebirth" (Throsby2008), or 'before' and 'after' narratives (Maor2013;Young& Burrows2013), evidenced in the current popularity of television 'make-over' programmes – but visible also in myth and fairy-tale and in accounts of religious conversions, whether it is Cinderella and her Fairy Godmother or Saul on the road to Damascus. Given the ubiquity of transformation stories across cultures I suspect that I am not alone in falling prey to this particular fantasy.

I argue that ideas of transformation and rebirth are dangerous in the light of the rates of weight-loss that can be expected from surgery - although finding long-term data on the amount of weight-loss that can be expected from WLS is not easy. The longest-term study (Sjöström,et al2007) suggests an average of 12% of total weight will be lost when measured fifteen years post-surgery.

Karmali et al note that "(p)revious studies have demonstrated that bariatric surgery candidates have unrealistic weight loss expectations... This was also confirmed in this study...when comparing large-scale results of excess weight-loss following bariatric surgery versus the patient expectations prior to surgery, it is obvious that they have significantly elevated expectations for weight-loss." (2011p595). This is problematic both from the point of view of those trying to help people lose weight and for those who opt for surgery. In the professionals involved it could lead to such blind spots as:

[i] Offering surgery to patients with insufficient consideration of possible psychological obstacles that might be encountered – for example I interviewed a former addict whose weight had only increased when he gave up taking drugs and now, when he could no longer eat to excess due to the restriction provided by the surgery, he was wanting to use drugs again. He said he had not been warned of this possibility, nor had he been offered any further psychological help

prior to surgery to come to some resolution of early difficult experiences. In a situation where it is often the senior surgical staff who make the decisions about who needs psychological help, perhaps that is not surprising.

[ii] A relentlessly positive attitude which brooks of no failure, so that interviewees reported feeling they were praised only for weight-loss and that admitting to difficulties would not be heard. The psychologists and dieticians whom I interviewed reported this sort of approach among some of their colleagues and told me that they were aware of its counter-productive nature and were working toward changing it.

[iii] And, in cases where there was no medical failure of the surgery, then the patient could be blamed if they 'chose' to circumvent the restriction provided by it and did not lose weight.

The fantasy of transformation can also be problematic for patients if they expect to achieve a 'normal' weight, when the likelihood is that they will remain technically obese post-surgery because most people who receive NHS surgery start with very high weights. But, the Fairy Godmother did not make Cinderella into an ordinary girl, she transformed her into such a beauty that the prince fell instantly in love with her - so how can people cope with not only remaining technically obese but also with having substantial aprons of loose skin which produce a characteristic post-WLS silhouette, plus associated problems such as hair-loss and breaking nails? I gained the impression that most of the people I interviewed did not quite believe the information that between eighteen months and two years after surgery they would begin to regain some of the weight lost.

I fell into the excitement of seeing a magical transformation in which people shrank in the months between first meeting at a support group and then interviewing them at a later date. In my work as a psychotherapist it would not have occurred to me to express this openly, but in one of the earlier interviews I did not attempt to disguise my response. I quickly realised my mistake because the interviewee, Monica, (Chapter4:5) made it clear that she was struggling to live comfortably in her new, smaller body: she missed her bulk and felt diminished in every sense. Chastened by this I reflected on my own fantasies of

being transformed and realised that, despite years spent in self-help and consciousness-raising groups and further years of analysis, I still had an impossible dream that the body I wanted was attainable, that my Fairy Godmother would come and wave her magic wand.

1:6 My clinical interest

My clinical interest is another aspect of this thesis and I argue that a marriage of a critical Discourse Analysis (DA) and Psychoanalysis is too uncomfortable, but the differences can make for a fruitful result.

I have found the cross-fertilisation has informed both my academic and my clinical work. The body of work produced by my predecessors in Discourse and Conversation Analysis has deepened my understanding of talk in and as action, while the disciplined attention to the detail of talk that is required by both forms of analysis has given me another 'ear' with which to hear the talk in a clinical session. The acknowledgement of the part the researcher or clinician plays in the construction of the interaction, whether it be a research or clinical interview, is a crucial aspect of both DA and Psychoanalysis, as is the requirement to be reflective upon one's practice.

For clinical purposes it is not enough for me to look at *what* is achieved through talk – I also want to ask why *this* person, at *this* moment in their life, and in *this* conversation, would want to achieve that? And, if I have a possible explanation, how could I use that to assist such a person in the psychoanalytic process and, more widely, what can my clinical knowledge and experience offer to an understanding of what it is like to live with WLS? But, in the context of this research, I do not consider it appropriate, or ethical, to pathologise the participants by individualising explanations of their emotional lives, instead I aim to explore general understandings which may be useful clinically.

1:7 Outline of the Thesis

Chapter One – The Introduction

I have set the scene in which WLS is considered a reasonable solution to what is defined as an urgent problem and have argued that the individual is made responsible for their size while possible structural causes have been ignored. I have described the reflexive and embodied style of the writing and anticipated some of the possible dangers and criticisms. This led to an account of my choice of topic; to an expression of concern about the transformation fantasy inherent in WLS; and an outline of my clinical, psychoanalytic stance to the material.

Chapter Two – The Literature Review

The review aimed to ascertain the approach to WLS within the context of current 'obesity epidemic' discourses and to look at underpinning explanations of the causes and cures for obesity. In the publications specifically related to WLS, the psychology papers were mostly quantitative in nature and direct patient experience was absent. The main aim appeared to be to predict who would or would not benefit from the surgery. Most of the papers I accessed were drawn from a population which was within the first two years of the operation. I found relatively few reports which extended over a longer period.

There was little talk, from the patient's point of view, about hunger, satiety, and the relationship with food as it related to WLS. My study of journals devoted to appetite emphasized the complexity of talking about hunger, satiety and the relationship to food. What became evident was that there is concrete talk about post-surgery diet, but I could find little about what the change in the ability to eat might be like psychologically for those who had undergone WLS.

The qualitative literature, particularly that written from a DA point of view, emphasized the 'profoundly moral context' in which the discussion of WLS takes place. In this discourse, fat is stigmatized as ugly and unhealthy; personal responsibility for health is required; and candidates for surgery have to perform identity work which absolves them from past blame yet presents them as good

patients in the future. A 'simple obesity' is constructed for which WLS is a solution.

Chapter Three – The Method

In this chapter I describe my choice of a theoretical model; my position vis a vis combining Discourse Analysis and Psychoanalysis; participants and the rationale behind how I sought them; the reasoning the interview method; my search for the methods of transcription and analysis which were most likely to help achieve my aims; reflexivity and counter-transference; validation; and ethical issues and concerns.

DA argues that individual and social are inextricably intertwined, and traces how this is enacted through discourse; it takes account of power and offers a critical analysis of it; does not argue for a single truth, and is used to reflect upon and critically evaluate itself. Wetherell's "synthetic" approach (1998;2003;2007) to DA, as used by Taylor and Littleton (2006), was my choice because it gave me the tools to look at the before-and-after aspects of living with WLS.

Chapters Four and Five - The Analysis Parts I and II

In Part I, to deal with the absence of the experience of the individual in most of the research, I look in some depth at four individuals and how they talked of and accounted for their experience. I make reference to the wider discourses evident in the talk of the participants and expand upon them in Part II. I was surprised by the lack of talk about difficulties in coming to terms with the new identity as a smaller person, and of the loss of the use of food as an emotional prop. Instead there was hope of transformation, both bodily and behavioural, from a past identity of someone positioned as helpless to effect change, to a new person who could follow the post-WLS guidelines for eating which are like the diets already failed at. Noticeable was the distinction made between themselves as actively working to keep the weight off and those who did not – it was in this talk that fat people were most clearly 'othered'. Food was talked about in concrete terms, i.e.

as what could or could not be eaten, how and in what quantity: no sense of loss was expressed, only some relief at being freed by the restriction which made it impossible to eat large quantities.

Chapter Six - Discussion

I reflect on some of the discourses the participants had recourse to when describing their experiences of surgery, specifically those involving body size and health, and the use of WLS as a 'solution' to problems of overweight. There were dreams of transformation involving 'rescue' from an external source; the identity work necessary to account for the shift from being unable to control their weight in the past to the new, disciplined person they would become through the effects of the surgery; talk about food and healthy eating guidelines; and 'othering' disparagement of those who did not live up to the promise offered by WLS by regaining weight that had been lost; and the need for long-term support. I note some limitations of my study; consider what my study offers to the field; discuss some clinical implications; and look at possible future research.

Chapter Seven – Conclusion

Concluding comments.

1:8 A Note About Terminology

Medical texts, public health pronouncements, and the media tend to use 'obesity' when discussing weight. None of the interviewees did – they spoke of themselves as being 'large', 'a big person' or, rarely, as 'fat'. When they talked of others who either had not chosen to have WLS or who had 'failed' to maintain their weight-loss, they often described them as 'fat'. These usages have been debated in the critical health literature to such an extent that I decided I had to make my own choices about which terms to use. I cannot deny the debilitating effects of carrying really large amounts of weight, so I do refer to 'massive overweight', but I have tried to restrict my use of 'obesity' to discussion of public

and medical discourses. For the rest of the time, I retain the language of my interviewees.

Note:

1 Data are collected by the Health Survey for England (HSE) natcen.ac.uk and also by the Health and Social Care Information Centre (NHS Digital) gov.uk/government/organisations/health-and-social-care-information-centre.

Chapter Two: Literature Review

In the Introduction I outlined the 'war on obesity'; described the most common types of WLS; and discussed my reasons for choosing this area to study. This chapter is an account of the literature review I conducted.

2:1 Aims

The aims of this review are:
(i) To demonstrate the specific context and rationale for my study within the wider context of the 'obesity epidemic' discourse and its explanations of the causes of, and cures for, overweight.
(ii) To present an overview of the literature on WLS, both in terms of the findings reported, and of how the studies reflected the public discourses about the causes and treatment of obesity.
(iii) To note any gaps and use them to frame the questions I would explore with my participants.

2:2 The Searches

The searches undertaken for this Literature Review were done in stages. First I aimed to establish a rationale and context for the subject of my study. Prior to deciding upon the questions to be asked in this dissertation, I had done literature searches on attempts to predict who would be most likely to benefit from WLS. These searches were not in vain because there was evidence that the experience from the point of view of the people undergoing the surgery was rarely explored in depth. (Engstrom&Forsberg2011;Stolzenberger,et al2013).

I then proceeded, as detailed below, to employ both data-base searches and hand-searching of specialist journals to discover how the patient experience, with particular reference to the relationship with food, had been studied. I asked weight management service psychologists, dieticians and support group leaders

whom I met if they could identify any further reading which I had not found by other means. I also examined the reference lists contained in works I have read for relevant studies which I had missed.

Databases

BMJ Journals; Cochrane; Google Scholar; ISI Web of Science; PepWeb; PsychInfo; and PubMed.

Hand-searches

Obesity Surgery, Obesity Research, *International Journal of Obesity, European Journal of Obesity, Appetite* and *Fat Studies*.

Search terms

First search – patient expectations + patient experience + bariatric surgery and/or weight loss surgery + obesity

Second search – hunger + taste + satiety + obesity

Third search - narrative and/or discourse analysis + obesity + weight-loss surgery

Exclusions

First search - papers that did not look at *patient's* expectations.

Second search - There is a massive literature on the physiology of hunger, taste and satiety, so I included only the most recent qualitative papers, from 2005 to 2017, that were related to obesity. I found so few papers that explored the subjective experience of hunger that I included all I could find.

Studies

Tables summarising the books and papers included in the review are in Appendix 4**.**

Appraisal

I used the CASP appraisal tool for qualitative studies and the EPHPP tool quantitative studies. (Appendices 2&3) I also applied the CASP rules to my own paper.

Some Reservations

Mine was a systematic review, not a meta-synthesis – this latter is rooted in positivist, particularly medical, research and has gained the status of 'gold standard'. (Hammersley2001p544) in which procedural objectivity is valued and

subjectivity is treated as a source of bias which must be minimised. While this is central in medicine, particularly given the role of commercial interests in medical research (Goldacre2013), I question whether this is desirable or even possible in the study of less quantifiable issues.

Lynch suggests that "(t)he review should be 'written from a particular stand-point, to fulfil certain aims or express certain views on the nature of the research topic and how it is to be investigated, and the effective evaluation of documents in relation to the research being proposed.' (Hart1998p13)." (Lynch2014p14). My purpose was to systematically explore the research field in order to obtain an overview or map so that gaps would become evident.

2:3 Results

2:3:1 *The Case for WLS*

It is widely agreed that, in the short-term, i.e. less than two years, the many forms of WLS are the most effective treatment for weight-loss in morbid obesity, i.e. BMI>40, or >35 with co-morbidities, and for the reduction of the latter. (Chang,et al2013;Colquitt,et al2014) There is less data available for longer-term outcomes. Almost all the figures of success or failure of WLS were bedevilled by the difficulty of following patients up over the necessarily long periods of time to assess its effectiveness. Much of the literature demonstrates that even medical records cannot provide good coverage of a straightforward measure like weight. More detailed information on measures of health related quality of life or psychological adjustment to changed weight is entirely dependant upon patient cooperation. The research was done largely via questionnaire and this had very low response rates, even before surgery, much less fifteen years afterwards.

In their meta-analysis, Livhits et al (2012) demonstrated how nearly-impossible it is to compare studies because of the wide variety of measures used - some talk in terms of total weight lost, others in changes in BMI, and others in percentage of excess weight lost. Some separate out the different forms of WLS surgery

while others put them all together. Response rates are not always shown, and even where they are, calculations appear to be made on the assumption that those who are absent do not differ from those who continue in the research programme. Some studies have suggested that those for whom the surgery does *not* work tend to drop out of continuing care and are less successful at maintaining weight-loss. (Beck,et al2012;Cranwell&Seymour-Smith2012;Kim,et al2014;Salant&Santry2006;Simpson2015). Also, relatively few studies made over periods of more than two years were found - this cut-off is the point at which weight starts to be regained after surgery. The following are studies which spanned longer periods:

- O'Brien et al (2013) after ten years a 54% reduction in excess weight;
- Hsieh et al (2013) after ten years a 61.4% reduction in excess weight which is equivalent to an average decrease in BMI from 47.5 to 33.4;
- Sjöström (2013) after ten years there is an average of 17% of total weight lost.
- Sjöström et al (2007) after fifteen years there is an average of 12% loss of total weight.

In their fifteen-year follow-up of patients who had LAGB surgery, O'Brien et al suggest that, "(b)ecause obesity is a chronic disease, any proposed obesity treatment should be expected to demonstrate long-term durability to be considered effective. Yet for bariatric surgery, few long-term weightloss data are available." (2013p87) The most significant exception to this is the Swedish Obesity Subjects trial which began in 1987. (Karlsson,et al2007;Ryden&Torgerson2006;Sjöström,et al2004&2007;Sjöström2013)

In his *Review of the key results from the Swedish Obese Subjects (SOS) trial*, Sjöström (2013) demonstrates that WLS is the only treatment which produces an average of more than 15% weight-loss over ten years. It also has positive effects on risk factors for most cardiovascular disease over the same period. It reduces the incidence of existing diabetes - although that effect lessens over time (Ryden&Torgersen2006) - and has a preventative effect on the establishment of the disease. Overall mortality is reduced but, "(i)n spite of these favourable

effects, the measured total medical costs of obesity were similar after surgical and nonsurgical treatment." (Sjöström2013p231)

2:3:2 *The Desire to Eat*

Conventional treatments for obesity have little or no positive effect in the long-term (Sjöström2013;Dalloo2012;Garner&Wooley1991) which has meant that other methods of restricting, preferably permanently, a person's ability to ingest large quantities of food are sought. Jaw-wiring is only effective while it is in situ, and drug treatments have unpleasant side-effects which make them difficult to use in the long-term. Bypass forms of bariatric surgery reduce stomach capacity and the production of hunger-stimulating hormones, and increase those hormones that produce sensations of satiety - although these effects tend to diminish over time and are not universal. There is also a search for drug treatments which will produce sensations of physiological satiety. (Scholtz,et al2014;Schultes,et al2010;Scott&Batterham2011;Wren&Bloom2007) Both forms of treatment aim to deal with the physiological aspects of eating but do not attend to social and psychological reasons for consuming food. (Jumbe& Meyrick 2018;Ogden,et al2011&2015) My next search on hunger and satiety responded to these findings.

My next search was specifically related to my questions about the experience of hunger and the relationship to food post-surgery. I chose to consider what is meant by those people who are morbidly obese, when they talk of feeling 'hungry' and to explore how that relates to what both physiological and psychological researchers mean when they ask participants about it. (Mattes1990&2010;Pepino2014;Weingarten&Elston1990) A paper by Wood & Ogden was the only one I found which asked the question, "How has your relationship with food changed following your surgery?" (2016p2449) Their aim was to account for the range of weight change among WLS patients who were at least eight years post-surgery. They found that those who had been able to "functionalize" their eating and did not eat "…in response to emotions were successful weight losers in the longer term…" (ibid.p2450)

Most of the psychological research that involves eating post-surgery is about assessing the incidence of what are defined as eating disorders, such as continual grazing, or vomiting to relieve the discomfort of over-eating, either continuing despite the surgery, or happening as a result of it. Of the quantitative studies I found, many did not give the percentage of non-responses to mailed questionnaires (Delin,et al,1997;Foster,et al2001;Scholtz,et al2014;Schultes,et al 2010) and when they did, the response rate was less than 50%, (Ogden,et al 2005;Wolfe&Terry2006). A number of papers did not give details of questions asked or, if a standard questionnaire was used, no reference was offered - Coles et al (2008), Delin et al (1997) and Ogden et al (2005), were exceptions. Meana and Ricciardi (2008) excluded, without explanation, talk about eating in their book on WLS.

How to measure taste, hunger and satiety has been questioned by many authors (MacKiernan,etal2008;Mattes1990&2010;Mela2006;Murray&Vickers2009) who argue that these are categories of subjective experience, but much research assumes that the lexicon of each equates to the experience in all persons, is context-independent, and therefore generalisable. Thus individual differences get ironed out in the process of aggregation. Mattes (1990&2010) questions what it is that is being measured when individual differences cannot be taken into account. He found that it is not possible to predict actual consumption from reports of hunger, taste, or satiety because the reasons people eat are so many-factored, for example, habit, social custom, food availability, and emotional states. In his research, reported intensity of hunger was not an accurate predictor of subsequent consumption, which suggests that amount consumed depends upon more than simple hunger. He says that a common operational definition of hunger is that it equals the motivation to eat, but in studies he did on ‘free-living’ rather than laboratory subjects, ratings of hunger bore little relation to what was subsequently eaten. He concluded that often when we talk of hunger, we mean the desire to eat which does not necessarily have a basis in physiological lack.

Murray & Vickers support this argument saying that "(a)n understanding of the subjective experiences of hunger and satiety is important to the accurate measurement of the satiety that a food provides." (2009p174) They reviewed the literature on assessing hunger and satiety and found that most researchers persist in using the simplest of measures which presume that all participants read the questions as meaning the same thing. They comment also on how few studies are conducted by asking participants how they define hunger and satiety. "Our study was undertaken to help better understand, from the perspective of the consumer, the complexity of hunger and satiety." (ibid.p175)

These findings contribute to the idea that reasons for eating are complex, and simple restriction, through surgery, of the ability to ingest food in quantity may not be effective in all cases. Jackson et al (2017) make this point very strongly suggesting that patients are prepared for the surgery, in the way that a wedding is prepared for - but it is life afterwards which requires the hard work. Their participants felt unprepared for the changes that were involved in post-surgery eating.

2:3:3 *Differences between patients and professionals*

WLS is recommended on the health grounds of cardiovascular risks, diabetes, some cancers and sleep apnoea, but Ryden & Torgerson (2006), Throsby (2012) and Coulman et al (2016) question whether these are of greatest significance to patients. The latter found that the day-to-day problems of living with morbid obesity were of more relevance than the less obvious problems of cardiovascular risk or Type II diabetes. Not being able to wash without assistance, severe joint-pain, calf pain caused by movement, or the myriad difficulties of functioning in public spaces were of greater importance in the choice of surgery for patients, yet in medical terms may be considered insufficient grounds for surgery.

In their study, Jumbe & Meyrick found in addition that there was "…a contrast between patient and health practitioners' perspectives of a shared service and a postoperative 'cliff' defined as a drop-off in care." (2018p2449) They suggest

that the rooting of WLS within a medical frame, "…despite evidence that obesity stems from combined biological, psychosocial and environmental factors…" (ibid.2447) leads to a view that the surgery is the endpoint, whereas for patients it is the beginning. So surgical staff held the view that communication was good "…if weight loss was achieved, (and) an assumption was made that the patient was doing well even if they may be struggling mentally." (ibid.2452) Patients, and longer-term nursing and psychological staff, thought that more support over time was needed.

In the specialist journals there is a vast research literature attempting to predict which patients are most likely to lose weight and experience a reduction in co-morbidities through WLS, but less on what patients expect of it, or on what they regard as a successful outcome. How 'effectiveness' and 'success' are understood differs between professionals and patients. For example, a discrepancy between what professionals consider successful weight-loss and patients' ideas of a sufficient loss was reported. (Coulman2016;Coulman,et al2017;Crawford&Campbell1999;Foster et al2001;Grave,et al2005;Karmali,et al2011;Kaly,et al 2008; Ogden,et al2001,2015;Wee,et al2006;Wolfe&Terry2006). In addition, it is the case that lay definitions of healthy weight differ considerably from medical ones. (Crawford&Campbell,1999) The finding, that patients rated as worse even than 'disappointing' a weight-loss which would be considered a 'success' by professionals, is described by Foster et al as a "therapeutic dilemma" (2001p2133). It is also an ethical one.

2:3:4 *Critical Studies*

Throsby writes critically about the neo-liberal discourse of individual responsibility for health. In five papers she explored the discursive resources available to people who are, or have been, in the stigmatised category of obese. (2007;2008;2009;2012a&b) Using Murray's (2005p154) suggestion that it is the "collective 'knowingness' about fatness" which is used to attribute a range of negative qualities on the basis of perceived overweight, Throsby says that this is what overweight people attempt to resist. She "…asks what stories can be told in

this context about the origins of fatness in order to negotiate and resist the discreditation of the fat self." (2007p1562). Emphasising the theme of transformation from the pre-surgery self, she explored the "…material and discursive work … required to support the identity of the re-born post-surgical 'new me'." (2008p118). This new identity is "slippery" and "highly contingent" because it requires the individual to succeed after surgery while using conventional techniques of weight management, despite a history of previous failure, and also to manage the post-WLS body. Failure is individualised – the tool is not blamed.

The hierarchy of interventions to which overweight people are subject puts them into an invidious position: in order to qualify for the next level of treatment, they have to demonstrate failure at the previous one. This lays them open to criticism because "…the failure to lose weight is attributed to a lack of self-discipline rather than to the inefficacy of any particular intervention." (2009p201). There is a further bind for them because, in order to be deemed suitable for WLS, they have to demonstrate that they can maintain the bodily work (at which they have previously failed) of diet and exercise required post-surgery. The resources people who have undergone WLS appeal to in order to resist the accusation of 'cheating' with its connotations of moral laxity, emphasise the "profoundly moral context" (ibid.p201) within which they are judging themselves and being judged. There is "...a medical, social and cultural context of a war on obesity where the singular certainty that 'fat kills' prevails with entrenched tenacity and where medical practice is being rationalised in relation to that singular conviction …" (2012a,p13). This equation of obesity with ill-health which informs WLS is an over-simplification. A further simplification is idea that the surgery itself ends the problem, i.e. morbid obesity, whereas the operated-upon individual has to live with all the after-effects of both WLS and of having been obese. She calls this, (referencing White's (2009) account of leprosy) an "uncertain cure".

Throsby argues that making the choice to have WLS does not automatically mean that the individual is a cultural dupe and a victim of false consciousness who has blindly bought into the claims of the health dangers inherent in obesity as some Fat Activists suggest. She "…argues that obesity surgery is usefully conceptual-

ised not simply as acquiescence to the anti-fat imperative, or its brutal implementation, but as a complex interaction of interests, desire and power relations which is inseparable from deeply problematic anti-obesity ideologies, but which is not confined to them." (2012b,p2). She does not expand upon the role of the debilitating aspects of severe overweight in persuading people to undergo WLS.

In three papers also using DA, Knutsen & Foss (2011) and Knutsen et al (2011; 2013) investigated patient 'empowerment' courses for people undergoing WLS, and questioned whether this kind of approach actually creates dependency and compliance instead. They noted the paradox that patients had to make successful use of the programme, i.e. they had to demonstrate that they accepted responsibility for their own health and were making changes in their life-style appropriate for dealing with what would be their post-surgery state in order to qualify for WLS, yet they were being educated into greater 'empowerment'. So becoming empowered meant an acceptance of "…medical discourses and a disciplinary system of thought, representing a normative rather than a radical and empowering process…" (Knutsen,et al 2013p67). In this way individuals become morally acceptable and form their identities by conforming to current standards of personal responsibility for health. "The challenge of 'doing' empowerment is to make people choose to act in the intended 'right' way themselves." (ibid.p75).

Patients were traced through the programme and at first people described themselves as unable to control their consumption and feeling helpless in the face of an addictive relationship to food. "This justified their need for help." (ibid.p70). The treatment was their "ultimate hope" as they felt unable to sustain the necessary life-style changes without it. Diminution or absence of dumping symptoms concerned them as they feared that, without the enforced control, they would resume out-of-control eating with a resulting weight-gain. The moral obligation to maintain the weight-loss would then return and if they did not succeed they would blame themselves for failing to avail themselves of the opportunity surgery had given them. The emphasis on WLS as not being an 'easy

way out' was a means of constructing themselves as moral individuals – but the shame would be there if they failed to maintain the weight-loss.

Knutsen et al found that the nature of a society which castigates its fat members and attributes responsibility for their state to themselves was not questioned, rather the internalisation of shame was taken for granted. Neo-liberal health provision insists that it is a citizen's duty to actively control their life-style and not to do so is treated as morally reprehensible. In this context the researchers studied how participants negotiated and reconstructed identities throughout the course, in other words, how they worked to demonstrate their compliance by positioning themselves as 'good patients'.

2:3:5 *A Psychoanalytic Study*

In four papers written from a psychoanalytic point of view about the experience of WLS, Magdaleno et al (2010a;2010b;2011); and de Carvalho et al (2014), aimed to gain an understanding of the meanings that life experiences, in relation to a medical issue, hold for individuals. Their conclusions were what I expected to hear from my interviewees – but on the whole did not.

They argue that WLS "…interfer(es) in the delicate psychological balance in which obesity is situated (and) provokes post-operative experiences in patients which they are unprepared to deal with…" (2010b,p424). Their participants reported continuing problems with hunger - which they appeared to have great difficulty in describing. "When they attempt to talk about hunger and consequently, obesity, they end up with an imprecise, marginal description, with elements that tend to by-pass the problem, unable to determine which are the subjective aspects that sustain the symptom. They get lost in interminable explanations, motives and previous vain attempts, all with a view to 'combat' obesity." (ibid.p433) Magdeleno et al suggest that hunger was conveyed as being a generalised bodily urgency and discomfort and linked to feelings of emptiness and helplessness.

They also looked at the social and psychological impact of the dramatic weight loss due to WLS, (2011) and challenged the idea that its success or failure should be judged simply by the amount of weight lost or regained. (2010a) De Carvalho et al emphasised the importance of studying the effects of weight-regain on people who have had WLS which would be feelings of shame and defeat. "The patients who regain weight feel that, somehow, they have betrayed the trust of those who gave them a chance to lose weight. The feeling of defeat and failure may drive them away from the health care service, due to fear of not being welcome and not being understood by the health team." (2014p144).

2:3:6 *The need for long-term, post-surgery support*

Most of the qualitative studies I accessed stressed the need for continuing support post-surgery. (de Carvalho,et al2014;Grave,et al2005;Jackson,et al2017; Jumbe&Meyrick2018;Magdaleno,et al2010a,2010b;2011;Ogden,et al2011,2015; Wysoker2005) They emphasised the complexity of living with the new post-surgery body and diet, and stressed the fear of regaining weight that was evident in many participants.

2:4 Conclusion

In this review of the literature I have looked at both quantitative and qualitative research into bariatric surgery for the purpose of weight-loss. (See Appendix 4 for summary charts.) My intention was to gain an overall picture of how WLS has been approached in psychological research and to see whether or if there were any gaps. It has confirmed that the patient experience is not widely taken into account in the journals dedicated to WLS.

The quantitative studies demonstrated that it is the most effective method for sustained weight-loss and reduction in co-morbidities and, although the effects do lessen over time, it is still more effective than the alternatives. Most of the psychological research reported in WLS journals is quantitative in nature and

can be criticised in its own terms in that there were varying levels of participation often with a response rate of less than 50%; that the participants were within the first two years of surgery and thus in the phase of greatest weight-loss; and that the measures used varied and were often not comparable.

Obesity was treated as though it is a simple problem, a "singular" (Throsby) obesity, which takes little account of the complexity of its origins, and is reduced to a bio-medical issue (Goldacre2009) neglecting its social and psychological aspects. WLS is justified on the medical grounds of reduction in co-morbidities, but studies which asked recipients for *their* reasons for the choice of surgery found that the difficulties of everyday living as morbidly obese persons figured highly. A further area of difference between professionals and patients was that of what were regarded as successful or unsuccessful outcomes.

Of the qualitative studies, many emphasised the "profoundly moral context" (Throsby2009p201) in which obesity exists and of the efforts patients made to absolve themselves of blame for their condition. Themes of transformation and rebirth as a 'new me' often arose, but unrealistic or unrealised expectations were also reported with regard to the changed way of eating and of amounts of weight lost or regained. My searches also demonstrated the difficulties and complexities involved in talking about hunger, the desire to eat, and the relationship to food.

The review has raised these issues to be explored in the Analysis chapters:

- the experience of WLS
- hopes and expectations of WLS
- living with the after-effects
- hunger, food and eating
- weight regain
- professional and patient expectations
- need for continuing support

The following two chapters will take up these issues, first in relation to four individuals and then more generally.

Chapter Three: Method

As I concluded in the previous chapter, there was a lack (i) of the voices of WLS recipients; (ii) and of research into their relationship with food, either before or after the surgery. In this chapter I will be addressing how best to explore the gaps identified in the literature. I state the aims of my study, and describe the choice of DA as my theoretical model; my position vis a vis combining it and Psychoanalysis; participants and the rationale behind how I sought them; methods of data collection; the process of the research; some approaches to reflexivity as distinct from counter-transference; evaluation and validation; and ethical issues and concerns.

3:1 Aims

- To analyse interviewees' accounts of their experiences in relation to the discourses available in the culture.
- To gain an understanding of any changes in the participant's relationship to food after surgery.

3:2 Choosing a Theoretical Model and Method

3:2:1 Mishler says, "The intimate connection between how a study is done and its findings, between methods and content, is universally recognized …(but)… is rarely acknowledged or explicated in research reports." (1984p12) He adds that the separation of the method section in a report, particularly when methods borrowed from the sciences are used, hides the very human processes of selection and interpretation involved. For this reason I have been explicit about the process of choosing a theory and method for my study and also in my understanding of the motives and values which underpinned the choices I made from the data.

My search was for a method that fitted my epistemological stance and would answer the questions I was asking. It also needed to marry my training, initially in sociology and subsequently in psychoanalysis, with my own concerns about body size, and distaste for our culture's vilification of fatness. The method would have to be qualitative partly because I was seeking to explore experience but also because I do not think one can equate what is said in answer to any question with a fixed reality 'out there', nor see it as a transparent representation of an internal state. Accounts in an interview, or in any other situation, are created in response to the nature of the situation and in turn create it. In other words I do not hold a representational view of language but a constructionist one.

3:2:2 So I considered a number of different qualitative methods: (i) thematic analysis (Braun & Clarke 2006), but found this unsatisfactory as it meant the loss of precisely what I was looking for – the voice of the individual - since differences are ironed out. (ii) Charmaz's (2006) account of Grounded Theory, but rejected it because I was not seeking to build theory. (iii) Interpretive Phenomenological Analysis (IPA) (Smith 2004) is frequently used in health-related research, but it presumes that a single, unequivocal meaning of any statement can be discovered, independent of the context in which it is produced.

3:2:3 Conversation Analysis, developed by Sacks (1992), looks at the formal properties of talk to show how participants manage such actions as turn-taking, agreeing, or initiating a new topic. It is primarily concerned with the forms of talk and what is achieved through it, but not the wider social and political context. Because obesity is very much part of current public attention, both in the popular media and in governmental and medical health discourses, I decided that a model of DA incorporating a critical approach to existing discourses was appropriate to the exploration of how these had entered people's talk about their surgery. The discourse about obesity is located in this particular historical and cultural time, and the available options for talking about it are not equal. As Edley argues, "Some constructions or formulations will be more 'available' than others... This is because some ways of understanding the world become culturally dominant…" (2001p190). The dominant ways of constructing the

'obesity crisis' have the status of facts and I wanted a method that sought to explore how they had become normalized and whose interests they might serve.

3:2:4 With regard to my use of 'critical' above, I have not employed the top-down model used by van Dijk although I do agree that to seek an understanding of the nature of social power and dominance is necessary in order to "…begin to formulate ideas about how discourse contributes to their reproduction." (1993 p254) The people I interviewed appeared to have accepted the dominant view of 'what fat people are like', which then involved them in positioning themselves as no longer fat and othering those who either had not had WLS or who failed to maintain their post-surgery weight-loss, thus paradoxically perpetuating the abuse of power inherent in the discourse about obesity. I have taken an explicitly critical and politically engaged stance to my material, but that is common to many schools of thought within DA and not unique to Critical Discourse Analysis alone.

3:3 Discourse Analysis

3:3:1 *Background*

The discursive approaches in the humanities in general, and psychology in particular, arose in reaction to the perceived inadequacies of realist thinking. In the 1960's and 1970's, writers such as Schutz, Garfinkel, Cicourel, and Goffman, influenced British sociologists who also drew on the later work of Wittgenstein in their search for a challenge to the positivist tradition through phenomenology and ethnomethodology. This move away was taken up by anthropologists and social psychologists who championed social constructionism as a means by which to account for ordinary human activity. Integral to this way of thinking is a requirement to question the grounds, or taken-for-granted assumptions, of our theoretical models.

3:3:2 *A psychosocial subject*

Discursive psychology postulates a psychosocial subject, the first premise of which is that we are social beings, both produced by our culture and producing it. The individual and the social are inextricably intertwined although they are conventionally, in this culture and at this time, treated as distinct entities. I argue that, in the treatment for intractable obesity, keeping the individual separate serves a political purpose because it locates within the fat person responsibility for their condition which makes it possible to gloss over any structural circumstances which might be seen as contributing to their state. Lewontin (1993) makes this argument in relation to tuberculosis because, where there is poverty TB is rife, whereas when people are well-fed and live in good sanitary conditions, it almost disappears. So what, he asks, is the cause of TB – the tubercule bacillus or poverty? Archaeologists make a similar argument about the causes of the Black Death. They suggest that it was not the fleas or the rats or even the bacterium *Yersinia pestis* which accounted for the virulence of the plague which swept Europe in the fourteenth century, but the fact that there had been widespread malnourishment for some years, making populations less resistant to infection. My argument is that 'the obesity crisis' should similarly be viewed in its social and political context.

Language is one of the sites of the entwinement of the individual and the social in that it is a general system used in an infinite number of unique and particular situations to convey meanings peculiar to that user in that moment. Unlike in the realist traditions where language is treated as if it represents 'the world out there' or is a precise description of someone's internal state, in discursive thinking talk is viewed as action, it is purposive and achieves something. It is not a reflection of activity, it is "activity itself" (Wetherell 2007p663;Wittgenstein 1953proposition23p11). One cannot assume that when one is told something in an interview that it is a fixed, unitary, and true description of that person's state of mind, instead one has to assume that things are being attempted in that statement – the person could be giving the answer they think is wanted by the researcher; or the 'correct' answer depending upon the interest group to which they are addressing themselves; or trying to persuade themselves; or a range of different possibilities. In other words, one cannot 'know' what their intentions

were, one can only offer an understanding of some of what has been achieved through the talk.

3:3:3 *Discourse*

Discourses are not theorised as a simple matter of language use, much more is involved. "…(A) discourse is a term for regularities in how something is spoken about, and the positions that a discourse constructs for different people are called 'subject positions'." (Branney2008p575). Edley suggests that discourses "…encompass a whole range of different symbolic activities, including styles of dress, patterns of consumption, ways of moving, as well as talking." (2001p191). This is particularly relevant when looking at the considerable bodily change that is achieved through WLS. Discourses are seen as historically situated: they incorporate what is accepted as legitimate to be done and said - and what is inadmissible – at a particular time. Not all discourses are of equal status because some ways of understanding the world become culturally dominant gaining the status of facts and are treated as if they were the truth. This is demonstrated in the taken-for-granted nature of the 'obesity crisis' – to question it appears heretical. A critical stance requires us to explore how such dominant discourses become normalized and what interests they might serve.

3:3:4 *Rhetoric*

Relevant to my analysis was Billig's (1987) suggestion that talk is rhetorical. We enter into argument with, and take up or attribute 'positions' in relation to alternative accounts – which can result in a state of ideological dilemma in that we tend to take varying positions vis a vis ourselves and others. This was evident when some of my interviewees said, at different points in the interview, both that they did and did *not* overeat before surgery; or that people who are overweight should not be subjected to prejudice, yet used blaming discourses when talking about others who had been unable to make use of WLS to lose weight. It is also evident in my own battle between dislike of how people are stigmatised for being overweight, yet I look at fat in others or myself and

disparage it. Part of this process of taking positions involves designating those whom we choose to see as not being part of our own position, as 'other' – as Lin & Kubota put it, we have to construct the other in order to know who is the self. They quote Hall, "…there is no identity that is without the dialogic relationship to the Other. The Other is not outside, but also inside the Self, the identity…" (2011p3)

3:3:5 *Approaches*

Discursive approaches are many and varied and can be distinguished in a variety of ways. One form of division, suggested by Phillips & Jorgensen (2002), is that between those discourse analysts who espouse:

(i) post-structuralist or Foucauldian ideas, (Gillies, Hook, Parker, Walkerdine, and Willig), seeing us as subjects of such dominant discourses as those of the law and medicine;

(ii) an interactionist perspective rooted in conversation analysis (Sacks) and ethnomethodology (Garfinkel); and

(iii) and those of a more constructionist model (Billig;Taylor&Littleton; Wetherell) who see us as both created by, and the creators of, discourses, thereby incorporating both the former approaches. The model emphasizes agency in the choice of the many fragmented discourses which are available to us and will be the course I have chosen to follow.

Another form of categorisation was that used by Branney (2008) who looked at differences in the approach to subjectivity: (i) Hollway & Jefferson (2000;2005), in their Free Association Narrative Interview (FANI) model, take a Kleinian view of the psychoanalytic subject. Their "…theorization of subjectivity, follows psychosocial principles. This involves positing a subject – including a research subject – 'whose inner world is not simply a reflection of the outer world, nor a cognitively driven rational accommodation to it (and who) cannot be known except through another subject; in this case the researcher' (Hollway&Jefferson, 2000p4)." (2005p150) (ii) While Parker (1992), using Lacanian theory as his base, demonstrates how psychoanalytic ideas have entered the culture thereby

structuring our subjectivity. "For Lacan, we are symbolic beings who draw upon language to understand our world and ourselves, which means that self-knowledge is always socially mediated and full self-consciousness is impossible." (Branney2008p584). (iii) A third approach is that of Billig's (1999) Psycho-analytic Discursive Psychology (PDP), which suggests a 'bottom up' model of analysis, limiting our understanding of subjectivity to what can be read from the available text and talk. Frosh (2002) describes this as a 'flattening out' of experience, but Branney suggests that at least it "…offer(s) an approach for examining how what-is-not-said is not said." (ibid.p582)

As a newcomer to the discursive field I have sometimes struggled to distinguish what are the differences between theorists who style their methods by different titles, for example, I have used aspects of Gee's (1999;2011) method to transcribe and analyse my data, as did Emerson and Frosh (2009) whose work has also informed my approach, but Gee describes what he does as 'Discourse Analysis' and Emerson and Frosh call their approach 'Critical Narrative Analysis'. I have also been influenced by Taylor (2007;2015) and Taylor & Littleton (2006) who advocate 'Narrative Discursive Analysis' basing their work in Wetherell's (1998;2003;2007) call for a 'Synthetic' approach where "…critical discursive psychology, combines micro and macro discourse approaches including, increasingly, narrative analysis and often combines these with other approaches such as psychoanalysis or social identity theory in social psychology." (Wetherell 2007p665).

Taylor & Littleton state, "Our argument is that an expanded, discursive and narrative focus is needed to explore the possibilities and constraints which speakers bring to an encounter from their previous identity work, or, in other words, how they are positioned by who they already are ." (2006p25). Their focus is on how identities are taken up in on-going interaction. They introduce a sense of time by looking at how biographies are constructed "…produced for and constituted within each new occasion of talk but shaped by previously presented versions and also by understandings which prevail in the wider discursive environment..." (ibid.p23). They suggest that, in addition to the constraints upon

an account created by the available discourses, previous tellings constrain the teller as well - potentially 'troubling' their account. This seemed particularly appropriate to my study because the interviewees were, through the effects of WLS, undergoing considerable bodily change in terms of diminution in size and in what and how they could eat. What would the impact of these changes be on their accounts of themselves prior to WLS and on their projected future selves? I wanted to find out how they would position themselves in relation to anti-obesity discourses and to question whether there would be a problem in choosing which side to see themselves as occupying. This approach offered a way of exploring people's reflections upon the changes in identity occasioned by the surgery.

3:3:6 *My position*

Branney's choice of the approach to subjectivity as a means of distinguishing between models is also relevant when considering how to examine individual stories. Wetherell (2012) explores the notion of "affective practice" in relation to ideas of subjectivity. She says "…I am… interested in the individual person as a very particular and specific site of transformation and pattern-making, and in understanding the personal affective history of this individual." (Chap6,p3). She argues that there is no easy dividing line between social and psychological processes, "(i)nstead, my hope would be to explore the formation of pattern in people's affective lives through practices that cannot be deciphered into separate 'psycho' and 'social' lines." (Chap6,p17). This approach to the individual fits with my own model of psychoanalysis which takes account of the cultural and political influences upon us and sees us as being the products and agents of both our social situation *and* of our unique, individual experiences.

Although I am not using psychoanalysis as a methodology, my clinical training and experience inevitably inform my approach, and it is here that Billig's (1997;2006a) emphasis on absences in text and talk seems most pertinent. In psychoanalytic clinical work one is as interested in what people do *not* say as in what is said. Therefore, I found his account of repression useful in thinking

about the absences I identified in the Literature Review - and which I argue were also present in the talk of my interviewees. He suggests that repression is accomplished dialogically, that we learn both what is acceptable to say and what is not, "…language is both expressive and repressive…" (2002p185) and that this will be culturally and historically specific. Discursive psychologists do not deny "…that people have inner experiences or thoughts. It is just that these are methodologically always just out of reach. " (2006ap18). This is rooted in Wittgenstein's (1953) statement that we cannot *know* another's intentions in the belief that talk is an exact representation of motivation, but we can and do talk about what we impute from another's words and doings.

In a culture which is permeated by psychoanalytic ideas (Billig1997;Parker 1997), we use notions of unconscious motivations so that we talk about someone being unaware of things about themselves that are obvious to outsiders. If talk of emotions is socially constructed then "…it is not inevitable that the individual actor is privileged in producing more convincing self-descriptions than any outside observer can." (Billig1997p144) So, because psychoanalytic ideas have passed into common sense, he argues that it is legitimate within speech act theory to "…doubt a person's self-ascriptions, or…wonder at the failure to produce any self-descriptions; then (one) may speculate why the person cannot admit to themself what appears apparent to outsiders." (ibid.p144)

Thus, in Billig's terms, DA can note the existence of an absence, but cannot explore any reasons for it other than those represented by culturally available discourses, but that still does not answer why any one person would choose a particular form of avoidance over another. Billig suggests Psychoanalysis should be so modified that the unconscious is seen as dialogically constructed and not as a private repository or habitation of universal drives and impulses. This is the point where it and a DA such as PDP, based on Wittgenstein's philosophy, have to part company. As this is my conclusion it is legitimate to ask why I chose to use PDP as an important aspect of my method. I see it as a means of systematically bringing the social and political into an analysis; of providing tools with which to analyse talk and text and any absences therein; and it offers us a way of

identifying how frequently-used psychoanalytic concepts such as repression and projection are achieved in talk. DA in its PDP form, can help us see how things work, but cannot explore any reasons for why any one individual would make choices between available positions – something of critical importance in a therapeutic situation.

3:4: Participants

I did not recruit participants through hospital services because I wanted to approach people from a non-medical, non-official position, not as 'patients' but as individuals situated in their own lives, not in the clinic. As far as possible I wanted to avoid the situation Georgaca describes where, "…individuals have already been positioned within the medical discourse as patients, through previous encounters with the mental health system, with the implications of lack of agency, insight and meaning that this positioning carries…" (2014p56). This positioning of the individual seeking help as passive, waiting to be 'done to' by experts, is one that has been widely described in the literature on health research. My aim was to limit the extent to which I was seen as representative of an official medical discourse – while knowing that I could not legislate for how I was experienced. There was the added factor that, by choosing WLS, individuals are admitting to feeling helpless in the face of their inability to maintain weight-loss, and I wanted to provide as open a situation as possible to see whether this manifested as a further passivity regarding their weight in their post-surgery lives.

In order to recruit interviewees, I contacted local WLS self-help groups directly and was welcomed by most of them, with invitations to attend meetings. I spoke at the meetings, briefly outlining what I was doing and why, handed out my participant information sheets (Appendix 5) asking if anyone would meet me. More than twenty people offered to talk to me, but over the period in which I travelled the area doing the interviews, two had to withdraw because of complications arising from their surgery, two did not respond to my follow up

contacts, and I could not arrange a convenient time with one other because of our respective work commitments.

A total of twenty people were interviewed by me – twelve of whom I talked with briefly at the support groups and the rest I met just once. Four were group leaders, who had had their surgery at least two years previously, which was also true of two of the others. Twelve others were within one year of surgery, a further one was about to have hers, and another was in the early stages of a weight management service's process. I stopped at that point because I felt I had enough material and also that I was hearing the same story. As Edley wrote: "As an interviewer…there usually comes a time when one begins to feel as though you've heard it all before. People seem to be taking similar lines or making the same kinds of arguments as others previously interviewed." (2001p198)

All interviews lasted for a minimum of an hour and three extended to an hour and a half. The number of words varied from just over 7,284 with Kevin, a group leader, in which my recording equipment malfunctioned, to 20,675 which was the interview with Hannah. The majority were around 13,000 words.

The topics the participants talked about included: the route to surgery; the LRD; WLS itself; post-surgery diet; side-effects; weight-loss; weight-regain; medical staff's responses; humiliations of being fat; the support groups; and who was likely to 'fail'. The group leaders emphasized those described as not prepared to put the effort into making the surgery a success. It was with some difficulty that I kept two interviewees who had multiple medical problems - not all related to their weight – on the topic of WLS.

I also met with four WLS psychologists and a dietician in order to gain an understanding of how weight management services function and was fortunate enough to be invited to facilitate a focus group on the patients' experiences of the service at one hospital. I attended a conference on bariatric surgery and another on more general issues around food and eating.

3:5 Method of Data Collection

3:5:1 *The interview*

Gubrium & Holstein take the suggestion of Atkinson & Silverman (1997) that we could now describe ourselves as living in an 'interview society' in which it makes sense to see an individual as having something meaningful to say about themselves, and who is not dependant upon a representative to speak for them, which would be the case in a more collective social arrangement. " …(T)he interview may be seen as one of the 20th century's most distinctive technologies of the self. In particular, it gives an 'objective', 'scientific' cast to the notion of the individual self, terms of reference that resolutely echo modern times." (2001:2011p8) It also depends upon the notion that making the private public by talking to a complete stranger is a culturally acceptable thing to do. "It would therefore be a mistake to treat the interview or any information-gathering technique as simply a research procedure. The interview is part and parcel of our society and culture." (ibid.p12) Taylor & Littleton suggest that, "…interviews are culturally rooted communication situations in which meanings are reinforced, challenged and negotiated between interlocutors…" (2006p28) Members know the rules of the form, meaning that talk within this context can be seen as 'naturally occurring'. This is not to suggest that the interviewee is there "…to be to be mined for information they hold by a neutral interviewer who doesn't contaminate the products by any intrusion of their selves…" (Gubrium&Holstein2001:2011p12), rather it is a site for the joint production of each participant and of the topic/s of their talk. Gubrium & Holstein conclude that, "Although varied institutional auspices provide particular resources for asking and answering questions, prescribe the roles played by interview participants, and privilege certain accounts, interview participants do not behave like robots and adopt and reproduce these resources and roles in their speech activities." (ibid.p34) I will expand on this in my analysis and demonstrate how my interviewees positioned themselves in our conversation.

Relevant to my research, Taylor (2001) suggests that people who are at a significant point in their lives may volunteer to be interviewed because the topic being explored is pertinent to them at that moment. My choice of WLS support groups as a place to recruit interviewees took advantage of this readiness, although I cannot claim to have anticipated it. This "…suggests a new interpretation of a research interview, as a congenial performance context for first person narration which speakers find pleasurable (Redman2005;Taylor2005). Specific to the narrative-discursive method, the new telling which would occur in an interview may form a part of the on-going rehearsals of the new identity." (Taylor&Littleton2006p7). The willingness of my interviewees to talk seems to confirm this.

3:5:2 *Meeting face to face*

One of the most important factors motivating this research was my wish to hear the voices of those who had experienced WLS, and to be in their presence in order to get a sense of the embodiment of it, therefore meeting face to face was essential. This desire to hear peoples' own accounts was not prompted by a belief that somehow this would produce a privileged answer closer to the 'truth' in a realist sense. It does rely for its meaning on what Silverman (1987;1993) calls a "romanticized discourse" in which the individual is seen as having their own story rather than simply being part of a larger whole. I am aware that the story is never finished, it is always in a state of production in each new telling.

Although I considered using email as a means of eliciting responses, as a clinician I could not imagine that I would get as full an account as if we met in person. I suspected also that there would be some people for whom expressing their thoughts and feelings in writing would not be a natural way of communicating and that by using email I would lose them. For practical purposes, to reduce the amount of travelling involved in the interviewing, I also thought of using the telephone but rejected it on similar grounds. I wanted the full range of communication and response. Importantly, if I had not seen the dramatic changes in body size and shape that occurred in the months between first

meeting people and the subsequent interviews, I would have missed the enormity of the impact of the surgery.

As I have already mentioned, I was aware that my relative slimness would probably have an effect on what people felt about talking to me - as would my age, style of dress and accent. I can only thank my interviewees for being willing to talk as freely as they did to me – most of them expressed surprise at the end of the interview that they had found so much to say and that they had enjoyed the process. I tried to make the interview as much a conversation as possible – it was not an interrogation but more of a mutual exchange (Mishler1986) - so I followed where the other person led because I was interested both in what they were telling me and in how they constructed their account. After reiterating that my interest was in their experience of WLS, thinking particularly about what had happened to their relationship with food, I left it to them to start the convers-ation wherever felt relevant.

3:5:3 *Questions*

As I have just explained, my approach to the interviews was to follow where the interviewees led and to treat the interview as a conversation in which I participated – largely only by asking for clarification where necessary. None of the interviewees needed encouragement to talk. If the participant strayed from the initial questions into areas unrelated to either WLS or food, I would remind them of the questions which were:

(i) 'I would like to know about your experience of WLS?' I asked this because, in the WLS literature, the patient's accounts of their experience of surgery were scarce. I consider that the absence of the patient's voice may signify a repression (Billig 1999) of the idea that these were more than bodies being operated on, that there were real human lives being materially affected by the surgery.

(ii) 'What has happened to how you feel about food now that you cannot eat in the way you used to be able to do?' I asked this question because, even in the

qualitative research I read, very few people seemed to have asked it and those who did got very few answers. The focus seemed to be more on changes in the body and not on what was consumed, but in order to become very large I assume that really significant amounts of food need to be eaten which would take up a lot of time, money, attention, and effort, to the extent that, if it all suddenly ceased, a substantial gap would be left. I imagined that this would be felt as a real loss which may necessitate some sort of substitute.

The way in which I asked my questions framed the likely responses to an extent. The first one tended to elicit a fairly linear narrative either of the individual's progress through all the medical hoops to surgery, often incorporating a history of their long struggles with weight, or a description of their childhood which they presented as contributing to, or accounting for, their weight. When I asked them to talk about the changed role of food in their lives and asked what has happened to the empty space that food used to fill, they answered with the regimen given them by the hospital. I added a third question about who they thought would be unlikely to benefit from surgery because it was an issue which came up in all the early conversations.

3:6: The Process

3:6:1 *Schedule*

- Made field notes immediately after participating in support group meetings and interviews.
- Listened to the recording, making notes of my reactions to it.
- Began transcribing – a detailed process which entailed playing and replaying the recordings. Each transcription was done before any further interviews because I wanted the conversation to be fresh in my mind to assist in the clarification of sections of overlapping talk or other forms of inaudibility.
- My first transcriptions were in 'play script', ie. as dialogue, with a much simplified version of Jefferson's (1984) notation – hesitations, stutters,

pauses, laughter, intakes and exhalations of breath, talking over, and emphases were all illustrated. When I did not know how to notate something, I gave a verbal description of it. (I would like to have been able to illustrate changes in volume and tone, but neither my recording equipment nor my hearing were of a standard to enable me to do so.)

(.) indicates a pause of less than a second

(2) pause measured in seconds

.hhh in-breath – more h's indicate a longer in-breath

hhh. out-breath - more h's indicate a longer out-breath

(J: mm) comments in brackets are continuers in the flow of the interviewees' talk

{ talking over

- Listened again and again to correct any errors in transcription.
- Listened while reading the text and not correcting but aiming to get the sense and flavour of the whole interview.
- Throughout all the above processes I was keeping a diary and making notes of common themes across the interviews and exceptions as well. I was also noting any narrative forms and looking for wider discourses being used or argued against. I made notes of my own responses both to what I was hearing and to the experience of doing research.
- As a preliminary stage, I began, using Braun & Clarkes' (2006) description of thematic analysis, a process of selection and coding in order to find themes across the data but found this unsatisfactory.
- I then used a version of Gee's (1999;2011) transcription method of putting the text into lines and stanzas. He describes speech as coming in "spurts" (Gee1999p148) and his method of transcription takes this into account by dividing talk into "lines" which usually have "…one salient piece of new information." (ibid.p154) and "stanzas" (ibid.p157), ie. a cluster of lines which have a unitary perspective.
- Collecting the text into lines and stanzas produced sections relating to a (usually) single idea or subject. The headings I gave to the stanzas provided themes and I was able to look across the interviews to see the commonalities and the differences. I then systematically asked a number

of the questions Gee suggests (Appendix 6) in order to ascertain what was being done and achieved through the talk.

- I was a member of a DA workshop led by one of my supervisors to which I was able to take samples of my transcripts for discussion. This was vital in helping me gain some distance on the data.

3:6:2 Arranging the text into lines and stanzas involved a very close reading and functioned as a move from transcription into analysis because one was already making analytic choices in the selection process. Creating stanzas enabled me to produce headings which I collected together, in effect as themes. I then was able to compare across all the interviews to see which topics arose most frequently; which addressed my research questions; and which were exceptions.

Gee's prescription is for moving from a close linguistic analysis through to one taking account of wider discourses, in other words it is in line with Wetherell's 'Synthetic' approach. He gives twenty-seven "tools" or questions to ask of one's data, from deixis through a series of further tools which travel outwards from the fine detail to his final tool which he defines as asking what identity a speaker is seeking to enact – within which discourse are they speaking? He does not prescribe the order in which the tools should be used. It is a 'bottom up' method involving a very close scrutiny of the data. This took a lot of time and practice, but it immersed me in the data.

The analytic process itself was 'bottom up' in that I familiarised myself with the detail of the transcripts, trying to keep my theoretical preconceptions at bay while looking at what was actually said and not at what I thought had been said or what I had expected. This process produced many surprises as I aim to make clear in the Analysis and Discussion. Over time, through my own readings and in the DA workshop discussions, I began to recognise recurring features or common elements, among the most notable being the lack of any talk, with one exception, about the loss of food as part of the respondents' emotional lives; there was a great deal of talk suggesting a lack of agency; excitement at the physical transformation; and evidence of a fattist discourse. This form of

analysis is an iterative one so that over time new ways of seeing, potentially deeper ones, become available and I am sure there is far more to my data than I have yet seen.

3:6:3 In addition to seeking patterns and exceptions across the data, I also looked more deeply at the work being done in each individual interview. I selected three interviews as representing patterns which occurred across the others, and one which was very different and gave evidence of 'trouble' in the experience of this new identity as no longer a very fat person. This contrasted strongly with other speakers' delight in their new-found smaller selves. It was necessary to look at how each had positioned themselves in their pre-surgery lives and how they presented their current and future biographies lived as newly thinner people.

3:7 Reflexivity

I have aimed to have reflexivity running as a vital thread through the whole of this thesis. Georgaca offers a beautifully simple definition of it as being "…the ability to take oneself as an object of thought and speech… "(2001p227). In the following I look at some approaches to reflexivity and then distinguish it from the concept of counter-transference.

3:7:1 Wilkinson (1988) distinguished three aspects of reflexivity which she described as personal, functional and disciplinary. The first two place the emphasis upon slightly different areas in that the first, the researcher's own identity, influences the second, i.e. the area of study selected. The third is the exploration of the theories and methods chosen, which in turn are a reflection of the first two. Who we are is reflected in what we choose to study and how we do it. From her position within a feminist social critique, Wilkinson is highly critical of male dominance in academic life and says that disciplinary reflexivity "…must take account of the dominant paradigm and the ways in which the operation of that paradigm is supported by the institutions of academia." (ibid.p496)

3:7:2 Hollway & Jefferson (2000;2005) and Elliot et al (2012) make use of the psychoanalytic concept of transference to research in a reflexive manner. Elliot et al suggest that, "(r)eflexivity in qualitative research is increasingly seen as a resource for understanding data that are embodied, unspoken or unavailable to consciousness." (ibid.p433). Hollway expands this to say that it "…involves researchers' considering and taking into account how their positioning affects their understanding of participants' meanings. Psychoanalytic epistemology goes further to state that the unconscious movement of ideas (from patient to analyst and from analyst to patient) transforms the meanings that are communicated; the meanings are in excess of the current situation because they unconsciously draw on archaic relational patterns internalised by each of the participants." (2010p142). I am uncomfortable with this adoption of constructs arising out of clinical work, to then be used as evidence of an interviewee's unconscious psychic state. It leaves out the necessary testing by way of an interpretation which is possible when working therapeutically. This shift from a sensitivity to what the researcher brings to a situation, to the presumption that the information produced by that sensitivity is a description of the state of the other, goes beyond what is available within a discourse analysis.

3:7:3 Finlay distinguishes five variants of reflexivity while acknowledging the artificial nature of such a division:

(i) Introspection - she warns against the dangers of navel-gazing suggesting that it "…should be exploited only while it remains purposeful to do so." (2002p215) A timely reminder for a researcher with a psychoanalytic training in which self-analysis is a continuing process. The risk is that the researcher's introspections might overshadow the stories of the participants.

(ii) Intersubjective reflection - exploring "…mutual meanings emerging within the research relationship" (ibid.p215) which are both situated and negotiated. Finlay expresses concerns about the use the concept of transference to interpret the unconscious aspects of the research relationship: "Isn't it problematic to simply import therapeutic techniques into the research encounter without question? And who am I, simply by dint of my training, to be so sure when

interpreting another's world? I am uncomfortable about the power I assume when explaining others' motives." (ibid.p218)

(iii) Mutual collaboration - a situation in which the researched act as participants in the evaluation and analysis, but Finlay cautions that this can disguise the essentially unequal relationship between participants and author. It also suggests there is a reality to which only members have access that would give the findings the status of a truth.

(iv) As social critique - demonstrates the oppressive nature of some research. But, while the proponents of social critique aim to diminish the authority of the author/researcher, they must avoid making claims to a greater authority because it is argued to be more valid.

(v) As discursive deconstruction - explores the multiple meanings used in language and the actions achieved thereby. The risks of this method are that the phenomena being studied may be lost in the analysis of how particular positions are being achieved through talk; and that the researcher could end in a place of complete relativism where she can lay no claim to the value of what she has done. In reference to Potter and Wetherell (1995), Finlay says, "Paradoxically, attempts to critically evaluate and deconstruct become, themselves, rhetorical strategies to claim authority and credibility." (ibid.p226) *'Oh the tangled webs we weave*….' (Sir Walter Scott).

3:7:4 In conclusion, I regard reflexivity in my research as a continuation of the process of self-reflection essential to my functioning as a clinician. It is also there in thinking systematically about how the participants and I interacted, how we constructed the situation, and in trying to understand what each of us achieved in the process. It is present in my critical awareness of the social and political framework within which WLS takes place, and in my questioning of the theoretical and methodological stance I have taken.

This is to be distinguished from the psychoanalytic concept of the transference which argues that archaic aspects of each participant's psychic life intrude into, or influence, the present interaction. My use of reflexivity is not a synonym for the concept of counter-transference as it is used in contemporary psychoanalytic

thinking. The analyst's counter-transference to the analysand is considered to be the sum of their subjective responses to the other, particularly the emotional responses, but evident also in apparently incidental occurrences like lapses of concentration or daydreams while in a session. These are understood and used as information about the state of the other. At times they are seen as a benign form of communication from the analysand, and at others as the result of a violent ejection of unwanted or intolerable mental contents into the analyst. This information can then be tested in interpretations offered to the patient.

3:8 Evaluation and Validation

3:8:1 Within the DA tradition, assessing the validity of a piece of work cannot be fully resolved since truth is endlessly in the process of construction and can never be finally reached. As Taylor puts it, "…truth claims cannot be checked because accounts of the world are not simply reflections or records of what already exists. They themselves constitute and change what they purport to describe…" (2001p12). Reflexivity requires the application of the same constructionist principles to claims of validity as to any other discourse that is studied. In order not to sink into a morass of relativism where every idea is as good as every other one, a degree of agreement has to be reached - but there is always room for discussion and dispute.

This is in marked contrast to the positivist position borrowed from the natural sciences where the 'world out there' is seen as directly knowable through language, and the criteria of reliability, objectivity, replicability, generalizability, and falsifiability (Popper1963) are unquestioned. The position of DA is a contrast and a challenge to the positivist hegemony, not a rejection of it. (Emerson&Frosh2009)

3:8:2 I will outline some approaches beginning with Potter & Wetherell (1987) who suggested looking for inconsistency and diversity in the data. They also emphasised richness of detail, and a clear explication of the process of analysis because the report itself is part of the validation. The fruitfulness of the findings

in generating new ways of seeing should be part of any evaluation of a piece of research. Wetherell (2001) argues that validity in DA is a complex concept which includes ideas of coherence, the generation of novel ideas and findings, plausibility, and grounding in previous research. These criteria are not unproblematic – coherence for example is not inherent in a text, it exists in the eyes of the reader and is therefore open to different interpretations. The requirement for coherence seems to devalue the recognition that contradiction and ambivalence are common features of discourse. Plausibility appeals to ideas of the collective production of knowledge which, as I suggest below, is a conservative position.

3:8:3 Emerson & Frosh consider that acknowledging the constructed nature of knowledge and "the inevitability of interpretation, underwrite increased attention to subjectivity and the validity of subjective knowledge…" (2009p38) Referencing Mishler (1990), they talk of 'trustworthiness' rather than 'truth' displacing traditional conceptions of validation. They argue that there are three critical aspects for the validation of discourse/narrative studies. The first is to make the texts/transcripts available so that readers can assess the methods, judge how representative the texts might be in terms of whether they can be generalised from, and "…provide a basis for the absent narrators/participants themselves to retain some control over their own words…"(ibid.p159). Secondly, analytic categories must be made clear with reference to the text; and finally, theoretical interpretations must focus on structures - thus talk can be "…linked to the power of dominant social discourses that can be seen both to provide discursive resources for their own reproduction and to restrain or prevent alternative articulations and associated subject positionings." (ibid p159).

3:8:4 Taylor (2001) emphasises that in DA we are talking about a different world-view in which research must be situated, contingent, reflexive, and non-neutral. We have to recognise that research itself is part of reality-construction. It can only ever produce partial knowledge because reality is not theorised as a single or static entity.

Given that much research within this tradition is on ‘sensitive’ topics, as mine is, Taylor warns that the work should be “…coherent, depending for its persuasiveness on argument rather than say, emotional impact.” (2001p320). The researcher can feel that “…the material which is collected may seem so powerful that it can be left alone to speak for itself.” (ibid.p320), but this would only be a description. This is echoed by Antaki, et al (2003) in their criticisms of much work presented as DA – the point being that it is not *analysis*. It is necessary to *do* an analysis of the material, rigorously and systematically. I wanted to hear the voices of my interviewees, not distort them by summary, or give an ‘expert’ interpretation of their stories, yet also to do an analysis which would count as sufficiently comprehensive to *be* an analysis.

Taylor rejects searching for the frequency of a feature in the data, as frequency does not demonstrate anything in and of itself, other than frequency. It has a value within a positivist model as a truth claim, but in constructionist thinking, the exceptions can be more revealing than the regularities. She criticises other truth claims such as that of ‘insider status’ giving the researcher the status of ‘one who really knows’; or the claim that by producing a highly detailed transcription one is demonstrating ‘what really happened’; or ‘member checking’ of the transcription or analysis. She ends her wide-ranging discussion of the problems of evaluation and validity by saying, “Ultimately, evaluation operates through persuading the academic community.” (ibid.p324).

3:8:5 As Phillips & Jorgensen (2002) argue, this reproduces the social order and its power relationships. This is a surprisingly conservative position which requires that discourse analysts remain true to their theoretical framework, rather than protecting their positions and beliefs, if it is not to become yet another hegemony. I have no better solution.

They agree that the report is part of the validation and as such must be clear and transparent so that readers are able to judge the researcher’s interpretations and conclusions. The analysis should be “solid”, and one way of achieving this is

to base it "…on a range of different textual features rather than just one feature." (2002p173). It should be comprehensive in that questions asked of the material should be answered, and any conflicts accounted for, and it should be transparent so that readers can conduct an "immanent critique" (ibid.p174) while reading. In the absence of complete agreement on criteria, "…the single most important criterion is to *explicate and follow the criteria of validity* to which one adheres." (ibid.p173).

3:8:6 From the discussion above I have selected my criteria of validity: (i) to be transparent, making clear reference to my data so that readers are able to make their own judgements on the coherence of my argument; (ii) to root my analysis in the work which precedes it, to provide a base from which other research can proceed, and to stimulate further work; (iii) to offer an analysis which makes sense to other native speakers, whether lay or academic. These combine to provide what I hope is a "trustworthy" (Mishler 1990) analysis.

3:9 Ethical Issues and Concerns

In the following I outline the practical steps I took to keep the process of my interviews, storage of data, and analysis in line with social science research conventions. Conforming to these aspects of ethical practice was straightforward, but other issues arose which were more complicated, interesting, and challenging, and I struggled with them throughout the processes of interviewing and writing. I will discuss this below.

3:9:1 Permission was obtained from the Research Ethics Committee of the Psychology Department of the University (Appendix 7). On first meeting the prospective interviewees I gave them copies of my Participant Information Sheet and Consent Form (Appendices 5&8). When we met subsequently – often months later – I took copies of both and asked if there were any questions. Usually there were not, so I repeated the assurances of anonymity and reminded them that they could contact me or my supervisor in the event of any concerns. The recorder and my computer are password protected. When making the

transcripts, I removed details which identified the speaker. The recorder, field diary, transcripts, and contact details of people I interviewed are in a locked filing-cabinet. A number of the participants chose to meet in public places which were very noisy so I doubt that our conversations were overheard.

In the field diary I recorded events and my reactions to them, and a number of issues kept recurring which raised ethical questions for me:

3:9:2 After attending a support group meeting I wrote that I felt as though I had landed in a world of walking wounded – or perhaps I should say *barely* walking. I was struck by the level of physical disability evident in many of the members, and the number and extent of medical conditions people referred to which could not always be attributed to their size. In the interviews, I heard of the illness and/or death of a parent during the person's childhood; neglect; alcoholism; violence; and sexual abuse. (Williamson,et al2002). Many were clearly living in straitened circumstances even though most were in work. Of those who did not have paid work, all did voluntary work. Taylor (2001) talks of much discursive research being done with "sensitive" groups, and this was certainly true of the people I met – not just in the sense of being a stigmatised group in the wider culture, but also in their own life experiences, personal and structural. This made it seem doubly important to treat them and their data with respect – without falling into sycophancy.

3:9:3 My second concern is about the way in which the analytic dissection of someone's talk can give the appearance of a 'superior' academic describing the activities of some lesser being, a 'cultural dupe'. I felt great sympathy with Wetherell's (2005) criticism of Hollway & Jefferson's (2005) treatment of their interviewee, and her expressed hope that he would not ever read their analysis. From my diary: "If I write about how Nichola (Chapter4:2) for example 'worked up' her narrative of pain and courage in the face of adversity – how does that sound? By putting on a brave face she is doing something admirable in our culture, but writing about how she achieves that doesn't sound particularly admirable." If I followed the suggestion made by many feminist researchers that

one's interviewees should be asked to give their opinion on what is written as part of the validation, that would make uncomfortable reading for Nichola and would be stifling for me. I do not think the issue is resolved by suggesting that it is inappropriate to share what one writes on the grounds that an analysis is done within specific academic conventions and can only be judged in those terms – but I do not have a better answer. It is still uncomfortable for me.

3:9:4 A prime reason for doing the research was to hear the voices of WLS recipients because they were absent in much of the research and, if they are present, they are referred to as 'patients' which immediately reduces them to their medical problems and airbrushes out their humanity. It narrows how the individual is seen to being simply their 'problem' which can then be treated in isolation by surgery. I consider that this process of absenting and silencing is part of 'othering' those who become hugely fat. But I am aware that I too am still using them for my own ends, i.e. to gain a doctorate, and it places a duty upon me to make use of my findings and analysis in a way which would be in line with my initial reasons for commencing this work.

3:9:5 Being a practising psychotherapist doing research in a non-clinical setting was a challenge. The people I met had consented to an interview, not to therapy, and there were a number of occasions when this became difficult for me. George had a history of drug-abuse prior to becoming overweight. When I first met him something made me suspicious that he might be on drugs of some sort. At our interview I thought I had grounds to be even more suspicious and then he told me that his "thoughts were going back to (a drug)". As a clinician, this statement, combined with my suspicions, would have been an opportunity to explore a concern which he had flagged up, but as a researcher I thought it would have opened up a sensitive area only for me to walk away when I had obtained the material I wanted. I experienced it as a real dilemma. He had told me that these thoughts worried him, and I was concerned that if he did not get help promptly he might be at risk of returning to old habits – *but* our contract was to participate in research not therapy. My compromise was to agree with him when he said he thought he should consult the WLS psychologist about it.

3:9:6 My familiarity with the long-term research, e.g. the Swedish Obesity Subjects Trial (Sjöström2013), into the effects of WLS, made me aware that the people I talked with were expecting, and reported being told by hospital staff, that they would lose significantly more weight than was in line with the research. While it was interesting and useful to think about the processes which might be going on with both the participants and the staff to achieve this, I could not lose my concern about the level of disappointment and the effect that might have, when the actual weight loss was at variance with what was expected.

As a clinician I was concerned more generally that the interviewees presented as being confident that they would manage the massive changes in their lives produced by WLS, without demonstrating an awareness of how and why they had become large in the first place. As a discourse analytic researcher I can accept that what people told me was particular to that situation at that moment and not necessarily indicative of actual mental states, but as a psychoanalytic practitioner I struggled with that and on occasion I did enter caveats. As with so many ethical matters, there does not seem to be a clear right or wrong – it depends upon ones' perspective.

3:9:7 Another entry in my diary is, "My current concern is that these people are all giving me their time and telling me their stories because they feel that their lives have been saved by surgery – how could I then write something that would highlight the barbarity and crudeness of the treatment?" The positions of my interviewees, (and myself) were not quite as simple as that, but the question still remains. Only two people queried my intentions with regard to WLS, telling me that it had received unjustified bad publicity, and saying they did not want me to add to that. I replied that my intention was to explore people's experiences of WLS not to either attack or promote it and, as I have tried to make clear in the rest of this thesis, I do not have a simple position with regard to it.

3:9:8 Given that I accept the researcher is not an objective, disembodied voice as positivist models would have us believe, my final question was about what I,

as a relatively slim woman, was doing researching into very fat people's experience. Frankenburg, writing about race, points out that whiteness is invisible to white people and we do not recognise that it structures us as much as colour does to others – the same could be said of body size. She says, "…look at racism, we tend to view it as an issue that people of colour face and have to struggle with, but not as an issue that generally involves or implicates us." (2009p522) I could substitute 'fattism' in that sentence. Non-fatness is normative: it is structurally invisible and is a position of dominance and bodily privilege. So my research could be seen as an act of compassion for those who have been 'othered'; or as prurient curiosity; or 'there but for the grace of god, go I'; or as fascination with the idea of a magical transformation. I think it is all of those, and probably more of which I am not aware.

Rice considers this issue and suggests that we should see "…ethics as a process of critical reflection…" (2009p245) in which "strong reflexivity" is practised. In other words, we should attend to the "…diversity of informants and explicate the ways that differences between researchers and respondents shape research processes…" (ibid.p246). Her solution, using Kristeva's (1982) concept of 'abjection', was to embark on a systematic exploration of her own desire to get rid of those aspects of her body which did not conform to stereotypical notions of an acceptable female form in order to become more sensitive to the experience of the people she interviewed. She argues that it is important "…to be accountable for the ways that personal experiences have marked my interpretation of women's stories" (ibid.p255) while maintaining a balance between enough self-disclosure to facilitate an assessment of the quality of an analysis, and not making oneself the centre of the work. I hope to maintain a similar balance.

3:10 Conclusion

This section has been a review of some of the theoretical and methodological terrain related to my search for a method of researching my questions about the experience of WLS. I have taken Wetherell's recommendation of a 'synthetic'

approach and have aimed to tell the stories of my interviewees in the context of the wider debates around fatness. She describes DA as "…that discipline which focuses on the situated flow of discourse, which looks at the formation and negotiation of psychological states, identities and interactional and intersubjective events. It is concerned with member's methods and the logic of accountability while describing also the collective and social patterning of background normative conceptions… It is a discipline concerned with the practices that produce persons, notably discursive practices, but seeks to put these into a genealogical context." (1998p404) In so many ways this is how I see what goes on in my consulting room as well.

Chapter Four: Analysis Part I

4:1 Introduction

4:1:1 This part of the Analysis is a close reading of four accounts of the experience of WLS with the aim of conveying something of the particularity of the people involved because so much of even the qualitative research in this area appears to regard the process of WLS as simply a matter of surgically adjusting bodies and no account is taken of the experience of the individual. I will make reference to the wider discourses evident in the talk of the participants and will expand on those discourses in the following chapter.

4:1:2 I came to this research as a psychoanalytic clinician and had assumptions and expectations which flowed from that positioning – one example being that most people who overeat to the point of morbid obesity are trying to eliminate feelings of emptiness. (Austin2013;Bruch,1957,1963-64,1969,1973;De Carvalho et al 2014; Farrell2004; Magdeleno et al 2010a&b,2011; Orbach1978; Sherman-Meyer2015;Tinter2009). As a result I anticipated hearing about some or all of the following:

- problems with the desire to eat because, in many cases, WLS makes eating in large quantities difficult because of painful and distressing side-effects.
- as the taste and texture of foods can change due to WLS (other than the LAGB), participants would express feelings of loss.
- that satiety could be reached quickly, but the sensation of satisfaction from eating, i.e. satiation, may be missing.
- replacement of food with the pursuit of other sources of satisfaction.
- the fear of regaining weight would be evident, particularly as WLS is the last option in a long line of failed treatments.
- adjusting to the extraordinarily rapid bodily changes would produce some difficulty, even shock – as would dealing with the effects of the changes on others' perception of them.

4:1:3 This chapter looks in detail at aspects of four transcripts from the twenty interviews conducted. I have chosen, through the process of transcription into lines and stanzas, systematic reading, and questioning described in the method section, three that represented the majority, and one which was an exception. My aim – a difficult one as Emerson & Frosh (2009) point out - was to both leave "…adequate reflexive evidence of how one has tried *not* to appropriate the voice of the participant and at the same time to show how one has entered interpretively into the text, including reflexively around the co-production of the interview and its retrospective sense-making." (ibid.p168 italics in the original).

4:1:4 I began each interview by asking:

- 'I would like to know about your experience of WLS?'
- 'What has happened to how you feel about food now that you cannot eat in the way you used to be able to do?'.

4:2 "*So, hopefully…*" Nichola

I chose to write about Nichola because she illustrates a number of characteristics displayed by many of my interviewees – particularly her larger than life, jolly, laughter-talk. Also demonstrated was her optimism that the surgery would solve a life-time of getting bigger, losing weight, and then regaining even more. Many of the participants expressed desperation over their inability to control their weight which led them to look for a form of control which was 'outside' of themselves.

Nichola and I first met at a WLS support group. A pretty woman in her early fifties, dressed and made-up stylishly, she was very large, walked with a stick, and was clearly in a lot of discomfort. At the meeting I asked if I could interview her and she agreed. A few weeks later we met at her home. Other than the warmth and generosity of the reception, I received an impression of a woman who, by participation in a local support group and attendance at all the

informational input which the hospital offered, had gained a good grasp of what to expect and how to manage the effects of the surgery.

Nichola's surgery had been cancelled three times at the point at which we met and she was about to start her fourth preparation. She began her account by bringing me up to date with the latest cancellation. Her manner of telling her story caught me up in its twists and turns – first I thought she was upset because of the cancellations, then it seemed to be the difficulties of being on the LRD, and the final dramatic turn came when she said she was unable to take her usual medications and as a result was in severe pain. I hope from her "troubles telling" talk (Jefferson1984a&b,2004:Jefferson&Lee1981;Edwards1995), which I will discuss in more detail below, it will be clear that it was not just a matter of being disappointed by the cancellations but also of dealing with the problems thrown up by the preparation. Evident is her assumption that I will "fill in" (Gee2011) all the background details of her talk in order to make sense of what she is saying. I also illustrate her use of direct reported speech (Holt1996) and discuss what it achieved.

4:2:1 *Laughter in 'Troubles Talk'*

51. N: *it's not so much doin' the LRD that I object to*
52. *the liver reduction diet (J: no)*
53. *because I don't mind that*
54. *I can do that*
55. J: *it's the disappointment*
56. N: *no it's coming off my drugs*
57. J: *oh are you what medication are you on*
58. N: *I've got arth- rheumatoid arthritis (J: oh)*
59. *so I've had to come off my main drugs my Z…*
60. *six weeks before*
61. *(.h) so six weeks before now*
62. *this is this'll be ten weeks*
63. *if it's cancelled t'den- again it'll be fourteen weeks*

64. and then I have to do six weeks after that

65. and now I'm on morphine

66. (.) for the pain

67. tse and also everything's flaring up at the moment

68. I mean yesterday I cou- huh huh

69. I was at work it was so funny

70. (.h) I said I'm going to be slow today

71. I can only use one hand

72. I can't type with the other one huh huh

73. (.h) 'cause everything's flarin' up

74. so that's what gets me-e

75. and because you get so tired and in so much pain

76. (.h) you just think is it worth it

77. J: (.h) that's awful

78. N: and I don't think people realise what happens

Note her shift from "I" when she's telling the story in a jokey fashion, to "you" when the joking stops: each move verbally distances her from the experience. The shift is evident again in the next quote, also my serious reaction to her laughter. Her use of irony and humour can, as Chapman suggests, "…help with (a) story's factual credibility because it is not just a moaner's gripe, but a story from someone not disposed to complain. So the irony can, ironically, reinforce rather than undermine the story's facticity." (2001p261) The use of direct reported speech adds to the impression that what is said is authentic – I was being given the verbatim quote so that I could evaluate it myself.

86. N: (.) if it was just the the diet I'd be fine (J: yeah yeah)

87. you know that would t-

88. it doesn't bother me

89. I'm losin' weight so fair enough (J: yeah yeah)

90. (.h) but um no i-

91. it's the main thing that I really object to

92. is the agony you go through

93. 'cause you're off your drugs

94. J: oh that's awful

95. N: mm so (.) tse I mean everybody else

96. is moaning about the diet huh huh

97. but I'm not

98. I've kept quite quiet

99. because I'm afraid huh huh

100 I'm going to lose it huh huh huh

101 and I want to remain cool

102 (.h) and and not like other people are about the diet (J: mm)

Nichola was unlucky to have had so many last-minute cancellations coupled with the need to stop taking her medications for a period before her surgery. She laughed a lot in her talk of other people who had sailed through the process having surgery at the first time of asking, and also of the rather faceless "they" who informed her of the cancellations. This laughter presented her as someone who resists their troubles (Jefferson1984), and positioned her as able to bear difficulties bravely unlike others who have it easy and yet still complain – *she* was not a 'moaner' or a 'whinger' (Edwards2005). In fact, "(s)omewhat counter-intuitively, laughter produced as part of a complaint can have the effect of enhancing rather than diminishing the complaint's seriousness and objectivity, precisely by displaying the complaint as counter-dispositional; the complainer is not disposed to make heavy weather of it." (Edwards2007p45)

104 N: other people must have exactly the same thing (.)

105 that they have to come off their drugs before an operation

106 and then y'know they're in agony

107 and they're tryin' to work (J: yeah)

Chapman (2001) illustrated how her interviewees often shifted the talk away from their own suffering and instead talked of how difficult it was for medical personnel or family and friends to cope with the diagnosis and treatment of cancer. She noted that this concern expressed for others showed that the

speaker was not just a self-pitying complainer, which would diminish the significance of their troubles talk but rather, like Nichola, they were demonstrating that they could look beyond themselves and were not selfishly engrossed in their own difficulties. In the process of generalising the suffering, Nichola was also making hers more credible and building an identity as a good witness.

109 N: (.h) I mean I come home and go bed huh huh huh huh
110 it's no existence huh huh huh (indistinct)
111 yeah so but I'll get there (.)
112 (.h) and that's the reason I I'm thinking about huh huh huh givin' up
113 (.h) but I've gone through so much to get here
114 that's the thing (J: yeah yeah)
115 and I just y'know (..)
116 the morphine that they gave me
117 they've actually given me morphine tablets now
118 which you have to sign for and everything (J: yeah)
119 (.h) and the dosage they had me on originally
120 I couldn't cope with (J: right)
121 I couldn't work (J: right)
122 I I was not compos mentis
123 J: {it was too much right
124 N: so now I o- I'm only
125 I'm putting up with the pain during the week
126 tse and I'll take the morphine at night (J: yeah)
127 um 'cause they're slow-release ones
128 but in the morning I'm like groggy
129 'cause I've still got it in me
130 huh huh huh so huh huh it's quite funny
131 (indistinct) they're good at work
132 I must admit they put up with a lot huh huh huh
133 J: but that is just awful
134 N: I mean last last week

135 when they put me on them

136 um I went into work on the Thursday

137 I was slurrin'   (J: yeah)

138 I was completely bombed out of my brain

139 huh huh huh ha

140 we'll send you back off the phones

141 don't speak to anyone huh huh huh

142 and then Friday when I went

143 I was just like I was hallucinating tripping

144 I thought no I can't do this no (J: yeah yeah)

145 um so huh huh I stopped them then

Again, the use of direct reported speech introduces the people at work as objective witnesses (Holt1996) of Nichola's state. Jefferson suggests that the noticeable aspect of laughter in "troubles telling" talk is that the recipient does not laugh along with the teller, but responds seriously to the import of the account - I followed this spontaneously during the interview. Although I was aware at the time of Nichola's regular laughter when describing situations most people would consider really unpleasant, I did not notice that there was a pattern to her laughter in what were less obviously troubling areas. When I came to transcribe the interview, I saw that she laughed whenever she mentioned that others could eat foods forbidden to her as a life-long dieter, yet they did not put on weight. The subject of her mother also produced a lot of laughter.

4:2:2 *The word "hope"*

Variations on the word *hope* appeared twenty times in the transcript. This could simply be because Nichola was still awaiting surgery and therefore in a state in which she could do nothing but be passive and wait. She was out of control of her weight and eating because she had made numerous successful attempts to lose weight by dieting, only to put it all back on again as soon as she stopped the diet. She described this process as though it happened *to* her, rather than

exhibiting any suggestion that she contributed to it. In addition, the number of cancellations she had suffered demonstrated her helplessness in the face of NHS systems.

Twelve of my other interviewees were in the first year after surgery which is the period of greatest weight-loss and most effective restriction on the amount that can be eaten. It is the time when many people experience few physiological hunger signals and also find the taste of some foods changes. This represented the majority of the attendees at the support group to which Nichola belonged. She was fraternising with people who were losing weight at a spectacular rate. WLS support group attendance tails-off at just the point when weight-regain is most likely to occur, i.e. between eighteen months and two years post-surgery. (Cranwell&Seymour-Smith2012;Throsby2008). So, given the group she was attending, Nichola's hopes were not entirely misplaced. Also, she and other interviewees reported hospital staff predicting amounts of weight which they could expect to lose that were significantly higher than found by any of the long-term studies I have been able to access.

Apropos the cancellations of her surgery and the next anticipated date:

286 N: so hopefully they'll do it on the third
287 but I'm not hopeful (J: mm)

This apparently contradictory statement creates an impression of control by being fatalistic about the possibility of cancellation. It is evidence of her genuine lack of control over when her surgery will take place – but by anticipating cancellation, she will not be taken by surprise.

In this next excerpt she was talking about her history of yo-yo dieting and getting bigger each time, and of how she cannot exercise at the moment because of the pain from her arthritis:

419 N: i*t's not that I'm eatin' excessively*

420 it's just that I'm not exercisin'   (J: mm)

421 and I can't it's very difficult

422 (.h) so um and I think that's the main problem

423 so I'm hoping huh huh um I'm hopin'

424 um because I know when I lost the weight last time

425 I was more active (J: mm)

In this she is performing a complicated manoeuvre to protect herself from blame – by appealing to the often repeated injunction to 'eat less and exercise more' she is demonstrating her knowledge of and acquiescence to it. She says she does not over-eat so the only way of accounting for her weight is through lack of exercise which of course she cannot do because of her arthritis. But the injunction is not directed only at weight-loss, it is part of an encouragement to adopt a 'healthier life-style', possible only if one is not hugely over-weight. Exercise is not an effective means of losing weight on its own and Nichola's last sentence suggests that being more active followed the weight-loss rather than caused it – but it still did not help her to keep the weight off.

443 J: what do you think it will be like

444 if you can't eat the same way as you did before surgery

445 N: I don't actually think that's going to bother me to be honest with you

446 as long as I can have a little bit   (J: yeah)

She dismissed any concern [455] about it and answered that as long as she could have a taste of the things she likes, that would be enough:

455 N: so that sort of thing doesn't bother me   (J: mm)

456 and I'm just hoping

457 like I say it's not

458 (.) I probably eat too much now

459 but I eat reasonably well   (J: mm)

460 but I eat too much of it (.h)   (J: mm)

461 so um

462 (.) I'm hoping that smaller portions um

463 with the diet that I tend to use

464 'cause I go for low fat no sugar um

465 I'm hopin' that it should come off

466 and it should stay off (J: mm)

467 so um hopin'

Having said that she does not eat "excessively" in the previous excerpt, suggesting instead that it is lack of exercise which accounts for her extra weight, Nichola now contradicts herself by saying that she "probably" eats too much, but she emphasises that she adheres to healthy eating guidelines. It would be only too easy to have recourse to the current cultural narrative, evident in the media and the pronouncements of some in the medical establishment (Jebb,et al2013), which suggest that the over-weight lie about how much they eat – if only to themselves. This would obscure the dilemma of people like Nichola who are caught in a vicious cycle of weight loss and regain and who, while demonstrating awareness of the blaming discourse (Wiggins2009) which attributes all fault for over-weight to the individual, still talked about their weight as happening *to* them. ([465-467]p75;[1230-1245]p77)

In this next section I had just said:

639 J: one thing people have said is that it's hard to eat

640 when you get no hunger signals

641 and things don't taste the same

642 N: yes I have heard that from a few people

643 and I know some people

644 that (.h) have become malnourished because of it

645 (.h) no I've got it in my head

646 that I must do high protein

647 and I'm (.) I I'm hoping it that'll stay there

648 (.h) I sorta like (vocal h.)

After a long aside about the family's concern about her elderly mother restricting her own diet because mother was worried about being too big – she continued:

740 N: so I'm hopin'
741 (.h) um if if it comes to that
742 I can't see it comin' to
743 because I'm pretty sure
744 the family would pick up on it
745 if I wasn't eatin' at all (J: mm)

This was one of five occasions where Nichola seemed to be externalising the responsibility for her eating by relying upon others to notice any problems, just as she was relying upon the restriction provided by the WLS to keep her consumption down.

In the following, Nichola had returned to talking about being on the LRD again:

1227. J: have you lost much weight
1228 N: I lost um (.) a st- one stone ten last time
1229 (.h) a-and I've probably
1230 because I've been eating normally for two weeks
1231 I've probably put about half a stone back on
1232 and that's how quickly it goes back on with me see (J: yeah)
1233 um so hopefully I'll lose another stone
1234 I might do a bit over a stone
1235 'cause I'm only doin it for two weeks
1236 (.h) so um (.) hopef-
1237 but the problem is
1238 the more times you do it (J: yeah)
1239 the less you lose (J: yeah)
1240 the first time I did it
1241 the first four weeks I lost two and a half stone
1242 (.) of course then I lost another stone (indistinct)

1243 but then I was off it from um October up until March

1244 (.) so you're eating normally

1245 so most of that went back on (.) so um (J: yeah)

1246 well it does prove that my liver does shrink

1247 so by losin' that amount (J: yes)

1248 hopefully

This juggling with figures of weight lost and regained was common in most of the people I interviewed, particularly in relation to how much weight they could expect to lose as a result of surgery. As mentioned above, interviewees reported hospital staff telling them that they could expect to lose far more weight than the long-term statistical research shows. Of course I cannot know if these reports are correct versions of what was actually said. The juggling of figures gives the talk an appearance of numerical, and therefore 'objective', respectability, and occurred in most of the interviews. It is also typical of dieting talk. (Stinson 2001;Johnson2018)

4:2:3 *Compliance*

Nichola made it very clear that she had done her homework and was able to say all the right things with regard to her projected surgery and its aftermath. She was demonstrating that she had done everything possible to prepare herself and had made sure that she was a well-informed, responsible and compliant patient who had accepted the neo-liberal discourse of personal responsibility for health.

She had just told me that if she had fish (without the chips) she would remove the batter:

610 N: only because I've trained myself to do it   (J: mm mm)

611 and I'm thinkin'

612 I don't know that I really want that

613 (indistinct) yeah I'm getting' there (J: good)

614 it's I don't think it's a quick thing to do (J: no)

615 and you have to train yourself

The idea of 'training' oneself to eat in a particular way is characteristic of the talk of WLS support groups and is part of the wider discourse around healthy eating. It appeals to cultural images of athletic or military training containing overtones of a resulting strength and discipline and, by using it, Nichola is presenting an identity of herself as being similarly ordered and in control.

615 N: you may not eat as much
616 but what you need to eat has to be quality

This was almost a mantra I heard from all the people I spoke with. Cairns and Johnston argue that the 'healthy eating' discourse "…reproduces and legitimizes fat-phobia. Despite its anti-diet message, this discourse repeatedly equates health with thinness and naturalizes weight-loss as an automatic and positive benefit of healthy food choices." (2015p171) Although no-one said so explicitly, 'quality' is opposed to 'junk', the latter being the bête noir of the healthy eating discourse. (Cairns et al2010;Johnston&Baumann2010;Parsons2013)

In the following Nichola demonstrates that she is sticking to the WLS guidelines of having 'proper' meals on crockery [763], sitting at a table as a family - which presumes that the home is large enough to have a table the family can sit at - and at set times of the day – which in turn presumes that work patterns are consistent and predictable. (PIL2013,Appendix 1) Current 'healthy eating' guide-lines (HSIC2015) fit neatly with the eating patterns of the social class which makes the recommendations, and they are treated as if they will, in and of themselves, make those who follow them lose weight. The guidelines for the 'right' way to eat are class-specific, and culturally and historically of their time, yet they carry an aura of being 'natural', and therefore correct. (Kirkland2011; Parsons2013;Simpson2015)

750. J: 'cause a lot of people have said
751. that they just have to make a point

752. of eating either three meals or six meals a day

753. N: {yes

754. J: depending and just do it

755. you just have to do it

756. N: {mm   'cause that's how I'm doing the LRD   (J: right)

757: you see with the LRD

758 I'm doin' the yoghourts' one

759 so breakfast I have yoghourt

760 and I have jelly right

761 and I sit there

762 in a bowl

763 not in the containers in a bowl

764 I have a meal lunchtime

765 (.h) I do exactly the same thing

766 (.h) and then I also do that of an evening meal

767 when he has his meal

768 I'll sit down and I'll have mine (.h) of that

769 and then bef- for supper I'll have another yoghourt   (J: mm)

780 so I've split the jelly into four huh huh

781 so and so I've

782 I don't tend to do anything in between (J: right) you see

783 so I'm trying to get it so that I've got um

784 but I've tried to do it so that

785 I've got a routine of having three meals a day (.)

Nichola emphasises that she is adhering to all the rules of preparation for WLS and for life after it. It is the same model which is offered by weight management services in the NHS before surgery is considered and, despite its demonstrable lack of success, continues to be the most common treatment on offer. (Dulloo2012; Dulloo et al2012; Garner&Wooley1991; Hill2004; Sjöström2013). This is based on the assumption that to eat less and exercise more is the simple and obvious solution to over-weight.

I asked all participants whether they had an ideal weight which they wanted to attain[785]. I did this because I thought that, given the strength of the fantasy of transformation in our culture, they would have a dream size which equated with conventional images of desirable weight. All of them denied any such hope. I cannot know if they said this because it was the right answer within the WLS community – which it was – or if, having been hugely overweight, any significant loss of bulk would be a sufficient reward.

785 J: do you have a weight you'd like to get down to
786 N: I just want to get down to what I was before
787 I don't want to be skinny
788 (.h) I got down to a size sixteen to eighteen
789 and I'm quite happy there (J: right)
790 (.h) I feel better
791 I'm confident
792 I look better
793 (.h) and I you know
794 I don't want to be a size ten (J: no)
795 that doesn't interest me huh huh (J: no good) huh huh
796 I'm quite happy
797 (.h) and this is what when I saw um uh the dietician
798 (.h) she said well you'll probably get down to about um (.)
799 you'll probably get down to about thirteen stone
800 I said that I should be delighted if I'm down there
801 I said I'll be happy if I get down to fifteen
802 (.h) so don't worry about that huh huh
803 (.h) uh I've I've not got expectations beyond
804 (.) I don't expect to go like that (J: right)
805 I'm hopin' I can go down
806 and I can stay there
807 and be happy as I am (J: yes)
808 so yes that's what I'm hopin'

This did feel very much like being given the right answer. I think my question elicited it.

Nichola's desire [788] to get down to what she was 'before' suggests a time when she was her real better self, when she was (and in the future would be) happy. Not unnaturally this sense of a before and after identity was strong in the interviews, after all the participants had, (or were about to), undergone major surgery in order to significantly change their bodies not just in terms of their size but also in the amount of food which could be consumed. The hoped-for identity was of a person who could restrict their intake and would no longer be at the mercy of a body which seemed out of control.

I asked [1373] if she had ideas about who the surgery would or would not work for. This was a question that I introduced because it was a topic that came up in the first few interviews and seemed to be one on which all the participants were willing to offer an opinion:

1373 J: um a lot of people have said
1374 that they have an idea of who it won't work for
1375 N: well I think all depends
1376 I can see some people um
1377 who-o (.) are putting it back on (J: mm)
1378 and I know why
1379 'cause they didn't sort out the problems before they had it
1380 tse and that's the reason
1381 and people moan about goin' to see the psychologist (J: yeah)
1382 (.h) but it's a godsend (J: right right)
1383 'cause you tend to open up more
1384 and to face the problems you've got
1385 (.h) cause we've all got eating problems
1386 or else we wouldn't be in this position (J: exactly)
1387 yes we've all got them
1388 but it's how you deal with them (J: yes)

1389 and um I must admit when I first saw

1390 I went to see her twice (J: yes)

1391 the first time I saw her she was ooh no

1392 and then the second time I saw her

1393 uh I'd got my head around everything

1394 and I'd got myself into a mind-set

1395 I knew what I was doin'

1396 she said you know

1397 I'd love you to come

1398 and discuss things with the groups that I've got

1399 'cause the attitude you've got now

1400 to what you had before (J: yeah)

1401 totally different totally yeah

Nichola's talk placed herself as no longer needing the services of a psychologist because she had got her "head around everything". Being in the ''right mind-set'' was a phrase nearly all my interviewees used.

4:2:4 *In summary*

Nichola personified the 'walking wounded' aspect of the physical toll that overweight puts on the body. Of those interviewees who were still suffering the effects of overweight like Nichola, there was a kind of pride in their difficulties manifesting in much medical detail which, when told with a lot of laughter, spoke of troubles bravely borne.

I also chose her interview because she was pre-surgery and therefore not in the honeymoon phase of rapid weight-loss which characterised many of the others. She exemplified the dream of transformation and rescue that Throsby (2008) also found which incorporates passivity and externalisation, where the rescue will come from an external source – in this case WLS. This positioning had to be counter-balanced by its opposite in which she showed that she was capable of the hard work necessary to make a success of WLS.

She demonstrated her status as a good neo-liberal subject or compliant patient (Knutsen,et al2011b) by making it clear that she knew what she 'should' do in that she said she ate according to healthy eating guidelines; did not have an ideal weight in mind post-surgery; and knew that she had to have the "right mind-set" in order for the surgery to be effective. She talked of herself as being ready for surgery having put in all the necessary work.

4:3 "*They said*…. " Hannah

I elected to write about Hannah, because our conversation illustrates the following most common features among my interviewees. (i) Her talk suggested a lack of agency and a tendency to make external her account of her motivations – she positioned other people as the active agents in her life whether it was in relation to how much she ate, the decision to leave her first husband, or the choice of WLS. Even when apparently reflecting upon herself she used explanations she had been given by others. (ii) She was concrete in her talk about food and eating, referring to the guidance given by WLS nurses and dieticians or to the current healthy eating discourse. (iii) She showed her knowledge of all the rules and told me that she was following them. (Knutsen,et al2013)

She approached me at a WLS support group, not on her own but in the company of George who was keen to offer his services as an interviewee. Having talked with her and spent time familiarising myself with the transcript of the interview, I think that her manner of offering to participate, ie. in the wake of someone else, was consistent with how she talked about her life during our conversation – for example, when I offered a choice of different venues in which to meet, Hannah suggested a coffee shop conveniently placed for *my* journey.

She had the characteristic, bottom-heavy, shape of someone who has undergone WLS, and had had a bypass a year previously, losing ten and a half stone (66.8

kgs) from an initial twenty-seven and a half stone (175kgs). She talked freely and quickly, needing little prompting.

Hannah reported drug and alcohol addiction and domestic violence in her extended family; her alcoholic father was removed from the family when she was very young; a few years later her mother became seriously ill and Hannah and her younger siblings were put into care for some months. When they returned, mother was still unable to look after them so Hannah assumed the role of major carer. She escaped into an early marriage where she described herself as being a carer again. She was always large, but at this point her weight ballooned. It was only when her mother died some years later that Hannah was able to leave the marriage "with the help" of her current husband.

The emphasis she placed on how helpful the WLS staff had been, conveyed a positive message and made a general advertisement for WLS – which would be in keeping with the proselytising other interviewees indulged in as well (Boero 2012). My approach to this interview will be to look first at how Hannah conveyed an impression of someone who externalised attributions of responsibility for her actions. Concrete talk and NHS culture will follow as the next two sections.

4:3:1 *Agency, Externalising, Responsibility.*

In response to my opening question about her experience of bariatric surgery, she began by talking about her meeting with the WLS psychologist and the effect this had on her.

8 H: *I'll start with Sally the psychologist um (.)*
9 just briefly um I
10 I always thought
11 I just overate
12 because I just was hungry um
13 but when I had my appointment with her

14 she said the reason that I overate

15 starting from when I was about twelve

16 was because I'd spent so much of my life

17 looking after my mum my brother and my sister

18 that I neglected myself so then um

19 I always made sure they were ok

20 then I would snack or pick or whatever um

21 and she said then that became a habit (J: right)

22 um so it was all about neglecting myself really

23 which is why I then started putting on the weight um

24 which was a real eye opener for me

25 'cause I had never looked at it like that

26 I just thought well I ate too much

27 'cause I was hungry

28 I'd never realised going back that far

29 that it was because I was actually neglecting myself

30 so that was a real eye-opener for me um (.)

By reporting what Sally said [14-23], Hannah was able to use it as an explanation of her previous over-eating. She referred to it five times during the interview in a way that demonstrated she was now taking care of *herself*, not just everyone else. Positioning herself as large only because she cared for others, to the neglect of herself, appeals to conventional models of feminine virtue, and looking after herself now appeals to a more modern, neo-liberal discourse of attribution of responsibility for self-care (Knutsen,et al2013;Warin&Gunson2013). She also showed that the responsibility for the account and for her actions lay with Sally – she was not self-aggrandising.

As I have said in my discussion of other interviewees' accounting for their weight in the context of the current blaming discourse stigmatising fat, many had recourse to explanations which absolved themselves of blame – factors beyond their control were responsible for their size. They positioned themselves as helpless victims. The tenuous and uncertain nature of this position means that

they were caught in a bind of blamelessness for their former size, yet accepted the WLS discourse of personal responsibility for making a success of the surgery in the future.

The surgery functions as an 'external' brake on eating: it was talked about as separate from the individual's desires, wishes or intentions. Here I illustrate that Hannah used other external brakes as well. In describing that she had never recognised hunger or satiety before WLS, Hannah spoke of how she was learning to recognise them now. It sounded a very mechanical process and sometimes she would only know that she had had enough when she put the food in her mouth and the texture of it made her feel ill [433-434p93], so at that point she would stop.

502 H: s*o I get a runny nose*
503 and I know when my nose starts to run
504 I need to take it and put it away
505 I say to my friends stick it over there
506 where I can't reach it kind of thing

The friends had to police the food for her. Or:

688 H: *even my husband will say to me*
689 you need to slow down
690 if we're out for a meal with friends

1180 H: *and I said to Luke (husband) …*
1181 and I said to him
1182 if you think I'm eating too much
1183 or you think I'm not eating the right things
1184 you know for god's sake tell me

She was putting the responsibility for how much she ate onto others [1180-1184] and said it was “still a constant battle” not to continue eating as she had in the past.

Another example of how Hannah positioned others as the active agents in her life was demonstrated in how she described the ending of her first marriage. She did not leave her first husband because the marriage was unhappy. She only felt able to leave because she had no children – she said she would have stayed if she had had any. She would not have remained because she wanted to, but because she saw it as being the right thing for the children. Again she was demonstrating that her former self put the needs of others before her own.

96 H: *although I stayed with him*

97 until I was twenty six uh

98 when my mum died

99 no sorry my mum died yeah

100 when I was twenty six um

…

106 but at that point I was already probably (.)

107 twenty six stone (165kgs)

108 because I used to snack a lot in the evening um

109 Pete would be in one room

110 and I would go into my bedroom

111 just to be away from him

…

133 but the death of my mum

134 woke me up a bit um

135 I met my current husband Luke uh

136 we were very good friends um

137 and when my mum died

138 I realised

139 I didn’t want to live in a one-bedroomed flat

140 with a guy

141 looking after him the whole you know

142 I wanted to have children settle down um

143 J: (indistinct)

144 H: yeah so with Luke's help I

145 I made the decision to break up with Pete

In almost all her talk she brought in the role others played. She did not say that she had asked for WLS, she said that her GP suggested it. When her clothes became so loose "they were falling off me", it was a friend who took her shopping and "made" her try on smaller sizes. When she worried about showing her "flabby skin" in a swimsuit, it was made alright by her husband saying, "you're never going to see those people again". She said of herself that she had become a "feeder", but her description was of her mother-in-law's over-feeding activities.

When I asked how she felt about the possibility of regaining weight, she replied by telling me what the dietician had said about how much she could expect to lose [1146]. When I suggested that it might be difficult if she regained weight [1160-1164] she told me of someone else who had regained all that had been lost and more [1170-1174].

1117 J: how do you think you will feel

1118 when your weight does stop

1119 H: um.

1120 J: going down

1121H: well when I saw the dietician before surgery

1122 she asked me what my ideal weight was

1123 and I said I didn't have one

1124 'cause as long as I lose weight

1125 I wasn't bothered

1126 I don't I never set a set goal in my mind

1127 'cause I don't want to disappoint myself

1128 so to be honest

1129 if I stay at seventeen stone

1130 I'll be more than happy

1131 because. I was twenty seven and a half stone

.....

1145 and she said she reckoned

1146 I would probably get down to about sixteen stone after two years

.....

1150 uh. and I'm down to seventeen two

1151 so. I and it's not been a year yet so-o (J: yeah)

1152 yeah if I don't lose another pound

1153 I'd be quite happy

1154 um I don't yeah

1155 I just don't want to set myself up for failure um (J: no no)

1156 yeah. a lot of people say

1157 oh they wanted to be a size ten or whatever

1158 but I just think that's not real realistic um (J: no)

1159 yeah so.. we'll see see what happens yeah um

1160 J: right (.) I think it can be quite a shock for some people

1161 particularly when not only do they stop

1162 but then they start putting a bit of weight on

1163 H: yeah yeah

1164 J: that's quite difficult

1165 H: yeah I mean some people have lost a huge amount of weight

1166 and they're literally skin and bone (J: yeah)

1167 um so then they go back to drinking fizzy drinks

1168 and then eating stuff they shouldn't eat

1169 and then they wonder why they've put on weight u-um (.)

1170 I know I met a woman recently

1171 who'd lost eight stone (J: yeah)

1172 um after having surgery

1173 and she's four years out

1174 and she's put that back on plus more

In the above quotes Hannah demonstrated her identity as a knowledgeable, realistic and compliant recipient of WLS who had set her sights at a reasonable level and thereby distinguished herself from others who cannot be successful because they do not follow the rules.

4:3:2 *Concrete talk*

When I asked Hannah if the dieticians had been helpful [1027-1029] her reply was filled with precise detail about what quantities were appropriate to eat:

1023. H: so um

1024. it is remembering

1025. what you've been taught by the dieticians' sessions and stuff

1026. um so yeah but yeah

1027 J: did you did you find all that helpful

1028 the stuff they gave you

1029 the dieticians

1030 H: *oh yeah absolutely*

1031 I'd never looked at

1032 like I said

1033 I used to eat too much fruit and veg

1034 I I just thought I was being healthy (J: yeah) I

1035 like she said to me

1036 a portion of raspberries was like

1037 or cherries

1038 was four or six

1039 well I'd just eat the whole punnet

1040 thinking I was being really good

1041 so when I went to one session

1042 and we did portion control

1043 and she said what did you have as a snack (indistinct)

1044 and I said oh a punnet of raspberries

1045 and she said oh a whole punnet

1046 and I went ye-ah

1047 she said well you do know a portion is about six

1048 and I was like .

1049 oh no no I didn't realise that

1050 so huh huh um yeah

1051 they really are helpful

Most of the interviewees gave this sort of detailed description of what it was possible or correct to eat. They talked of the pre-surgery LRD; the early post-surgery days when food had to be pureed; changes in taste and/or texture of particular foods; whether they could or could not eat sweets; and how much, or little, of a roast dinner they could eat now – but only George said he missed anything. They were recommended to eat only as much as could be fitted onto a tea plate – this to someone who previously would have eaten "a one kilo steak" (Tony) or "twenty roast potatoes" (Monica) – yet they did not talk of the change as any kind of loss. It was as if gargantuan consumption had been replaced by a minutely detailed focus on what it was possible to eat.

Hannah's descriptions of how she was learning to recognise hunger and satiety were, as I have said, mechanical and concrete. I do not intend that description in a pejorative sense. I was struck by how hard this woman was working to get a sense of what hunger and satiety were for her. She gave the impression that she had never been aware of either, and now was beginning to feel as though, by being able to recognise them, she was gaining some control over her eating.

321. J: so the messages aren't very clear for you

322. H: um no

323. J: so now what you think is hunger actually isn't

324. H: no that's right

…

334 *my head will say ooh I'm hungry*

335 and I will think

336 should I or shouldn't I

337 and sometimes I'll have a drink

338 and that doesn't satisfy me

339 so I think no no it must be hunger

340 because I haven't eaten

341 so I'll start eating a banana

342 but I know

343 as soon as I've swallowed that first mouthful

344 my stomach will go

345 no it's not me

346 I don't want food

347 so I stop

348 then I think

349 ok that is definitely just me

350 it's not my stomach wanting food uh

426 H: *sometimes I I can't manage to eat even a full plate of food*

427 so I manage as much as I can um

428 and then I just leave the rest so uh (.)

429 but I get a tight feeling across here (indicated her midriff) (J: yeah)

430 I know that my stomach doesn't want any more (J: yeah)

431 um I sometimes

432 even having one more mouthful

433 you know if you have one more mouthful

434 it's going to come back up :

435 J: *really*

436 so it's one of those points where

437 so you you would throw up if you

438 H: I would I would be sick

439 if I ate too much yeah um

1319 *H*: *it was almost like . it was giving me the control back*

5091 *H: and also now*

5092 *I I seem to be more in control of when I know I need to stop*
5093 *it's about being in control I think*
5094 *um and I feel I feel more in control now*
5095 *um before I didn't feel like I could stop so yeah*
5096 *J: yeah*
5097 *(indistinct) whereas before you'd probably say*
5098 *oh I shouldn't eat that 'cause it's bad for me*
5099 *but you eat it anyway*

The surgery provided a literal restriction to her consumption and enabled her to resist what in the past had been irresistible.

4:3:3 *Healthy Eating*

There is plenty of advice available from public health bodies on what constitutes healthy eating. It changes slightly over time, but the essence is that something like a Mediterranean diet is the most desirable with at least five portions a day of fruit and/or vegetables but, as with any dictum, it depends upon the context in which it is applied for its meaning. What counts as a portion is not simple – is it the portion of chips served in a fish and chip shop, or as Hannah thought, a whole punnet of raspberries? If one is part of a culture, whether family, class or nation, in which eating large quantities is the norm then a 'portion' is going to mean something very different when compared with the 'portion' of a health-conscious dietician.

When talking about a time she weighed twenty-two stone (140kgs) Hannah said:

155 H: *I didn't overeat too much*
156 but I think my portions were big
157 and then I would snack on fruit and stuff during the day
158 not realising that
159 until I visited the dietician group sessions
160 that I realised you can eat too much fruit

161 I had no idea

162 I just thought I was being healthy (.)

As with Nichola above, Hannah seemed to be saying both that she did *not* and *did* overeat – but it was 'healthy' food of which she ate too much thus demonstrating that she was well-intentioned by following the rules of healthy eating with enthusiasm and could not be accused of filling herself up with junk food. This was a protection against the narrative of fat people being careless in their eating habits because, for example, of the over-provision of 'junk-food' outlets in deprived areas (Roberts,et al2013). In a further demonstration of placing herself above 'fattist' criticism she talked about eating after surgery:

365 H: it is just

366 it's all about making the right choices

367 and having a healthy life style um

Hannah, and the other interviewees, made it clear that crisps, chocolate and "fizzy" were all bad foods and had to be avoided. In their talk around healthy and unhealthy eating all mentioned this trio, the consumption of which was a dieting mortal sin - and they all found them very difficult to give up.

588 H: *but I don't eat anything really that I shouldn't eat*

589 I don't eat crisps

590 crisps was my biggest thing um

591 especially when I was with my first husband

592 I'd sit in the bedroom

593 and eat a whole bag of crisps

594 a big one

And:

1204 H: I don't drink fizzy drinks anymore so

1205 um not that you can't

1206 but you can (J: yeah)

1207 it's about making the right choices (J: yeah)

1208 um and I'm very aware

1209 that having something once

1210 you shouldn't have

1211 can lead to having it more often

1212 it then becomes a habit again so yeah

1213 J: were were you a great fizzy drinker

1214 H: I was

1215 giving up diet coke

1216 'cause I only ever had diet drinks (.)

…

1226 and even up to. three weeks before my LRD

1227 I'd have a diet coke um

1228 it was one of the hardest things giving it up

1229 which seems silly it's just a drink really um

1230 J: it's not as simple as that

1231 H: it was easier to give up crisps

1232 than it was to give up diet coke um

1233 so I'm very aware that I wouldn't . have one again um .

1234 in case then it led to another one

1235 yeah so um

…

1245 (its) about having a healthy diet

1246 fizzy drinks aren't a healthy diet

1247 and they don't give you any kind of

1248 it's empty calories um

…

1254 so uh but I think for me it's more of a

1255 it's a healthy life-style you can have

1256 it (indistinct) so it's empty calories

…

1289 but um yeah so I'm very aware um (. 1 sec)

1290 of what I should and shouldn't do

The language of good and bad, should and should not, healthy and unhealthy, naughty but nice, with its simple dichotomies has strong overtones of much Christian teaching. This has been noted by many writers who have studied the diet industry(Stinson2001;Wolf 1991), and is a familiar one for people who have had WLS to adopt.

4:3:4 *Hunger*

Another aspect of eating that was problematic for participants was that many of them had lost any feeling of what they called hunger. By this I understood that they were no longer prompted to eat by sensations in their stomach, or the effects of low blood sugar, although other, less obviously physiological promptings remained.

396 J: um I'll stick with the hunger thing
397 'cause quite a few people have said to me
398 they don't feel anything that looks like hunger (.)
399 and they have to make themselves eat
400 otherwise (.) they would just go for days without eating
401 H: { I do get days
402 *when I don't feel hungry*
403 *but I know that I need to eat (J: right)*
404 *'cause I know those*
405 *I eat 'cause I know if I don't eat*
406 *I don't absorb protein and stuff*
407 *I'm very aware of that (J: mm)*
408 *um so whether I'm hungry or not*
409 *I have my three meals a day*
410 *which sometimes is a little bit difficult if you*
411 *you really don't feel hungry (J: mm)*
412 *um but bearing in mind that*

413 *I've got to look after myself*

Hannah said she would make herself eat thus demonstrating her conformity to rules of healthy eating and to the psychologist's prescription to look after herself, but fear of suffering from dumping caused some interviewees to eat very little. This does seem a problematic area for those having WLS and left me wondering what people do when they no longer get physiological signals to eat; when food tastes different and, by report, the change is usually for the worse, thus limiting choice; and they are fearful of dumping. (Not everyone has these changes in the experience of hunger and taste, and for those who do, the effects tend to diminish over time.) It is as though all the pleasure and rewards from eating have gone and one of the prompts for this piece of research was the question, 'What replaces them?'.

4:3:5 *The NHS*

Hannah talked about the services available from the NHS in ways typical of all the interviewees. These were the demand pressures on the WLS service; lack of funding; the helpfulness of staff; gratitude for having received surgery; and a feeling that she must not ask for more.

She described how her surgery had been expedited because of a previous error on the part of the hospital which had caused a delay. On talking about seeing Sally prior to surgery, she emphasised the high demand for such services. Hannah managed to demonstrate, by telling me that she had been able to take a last-minute cancellation, that she had not taken more than her fair share of a scarce resource, and she had not deprived anyone else [296] even though she had been moved up the list. She also illustrated that she was aware of the needs of others and worked up her identity as a carer:

285 H: s*ome people wait eighteen months to see her u-um*
286 *it's just ridiculous you know*
287 *she's so busy*

288 *I mean she did have somebody working with her for a while*

289 *but they had to let her go*

290 *don't know if it's still just Sally again now*

291 *or whether they've got somebody else*

292 *um but um*

293 *I was lucky*

294 *and also because I only got to see her the once*

295 *I felt fortunate*

296 *that I wasn't holding people up either*

In the following quote Hannah demonstrates her willingness to cooperate with the opinion of the psychologist, while denying any feelings of need or agency on her own part. Discursively I would see this as achieving an identity for herself of not being greedy or wanting more than her fair share. Her talk is of how helpful the WLS staff were, which was a position taken by many of the participants, in addition Hannah manages to show that she would not take too much of their time. Talking about more support from dieticians Hannah suggested that she would like more help to be routinely provided. In her identity as someone who cares more for the needs of others than her own, and who is not greedy, she forgoes the chance of asking for help from them.

1064 H: but I know if I wanted to see them

1065 I could ring up probably make an appointment

1066 they're very good like that (J: yeah)

...

1069 H: uh I'd have been quite happy to see her more

1070 if I needed to

1071 but she didn't feel I needed to

1072 but the door is always open

1073 she always says if you need to speak to me

1074 ring up and make an appointment and I'll see you (J: yeah)

1075 um but i think they ought to do the (fruit) session again (j: yeah)

1076 (indistinct)

1077 J: {you wouldn't have to feel

1078 that you're asking for something special

1079 H : yeah well that's it u-um

1080 J: {because you're a you're a carer

1081 you don't like to be looked after

1082 you don't like to ask for help

1083 H: yeah yeah so um that would be nice

1084 if they did do that

1085 but it's the funding

1086 they don't have the funding

When I commented that she did not seem to want to have to ask for the help from these very "helpful" people [1077-1082] I was taking up a position more suited to a therapy session than a research interview. She carried on as if I had not spoken. Hannah side-stepped my intervention by using the current discourse about NHS lack of funding. This also suggests that the dieticians were helpless to effect change and avoids the appearance of criticism of the hospital staff by showing her care for them in their difficult situation.

Feeling undeserving was a commonly expressed sentiment and fits with the idea that people who are overweight should not ask for more from a 'cash-strapped' NHS because they have already taken more than they need:

1310 H: *I mean I felt. before having surgery*

1311 *when I saw Sally*

1312 *I said I almost feel like (. 2 secs)*

1313 *I need the surgery*

1314 *it was like I was cheating really um*

1315 *I felt like I was cheating*

1316 *um having the surgery*

In this culture responsibility for weight is individualised and, as I described in the Introduction, the causes of the high preponderance of obesity in

disadvantaged groups is glossed or reduced to a geographical problem of too many fast food outlets in an area (APPGO.2003;Kirkland2011), so that the individual can still be seen as making the 'wrong choices' rather than the 'right' ones. Hannah used this narrative and simply did not respond to any suggestions I made that her previous over-eating resulted from her circumstances.

4:3:6 *In summary*

I have demonstrated how Hannah conveyed a lack of a sense of her own agency by externalising her accounts of her motivations. When asked about her own experience she was very concrete in her talk about food and hunger, having recourse to the guidance provided by the WMS dieticians and the public healthy eating discourse. I took portions of the transcripts of this interview to the regular DA workshop I attended in order to assess my interpretations of what was said. My colleagues emphasised the lack of agency and externalising, and commented on the concrete nature of Hannah's talk.

In her talk about the NHS she gave evidence of her familiarity with the current narrative of lack of funding; the helplessness of staff to change things; her good fortune at having had WLS; and her acceptance that she must not directly ask for more – something which conforms to the 'obesity epidemic' narrative that fat people have already had too much of what are scarce resources.

4:4 *"What do you want to know?"* Tracey

I have chosen to write about Tracey because she was the most vivid version of the group leaders I interviewed. She was an evangelist for WLS, emphasising how her life had been transformed, and insisting that it was not an easy way out – claiming instead that it has to be worked at by the individual to achieve success. In her view, those who fail to maintain their weight-loss simply have not followed the "basics" and deserve no sympathy. In this talk about people who do not succeed, she gave evidence of an adherence to the cultural narrative

of fat people being lazy and stupid which led to some trouble when she was reflecting on her identity pre- and post WLS.

She took control of the interview in a number of ways – positioning herself as the expert (which of course she was) and making me the one who needed to be told; she 'yes yessed' while I was speaking and talked over me unless I was asking a question; and she lectured me as though I was a member of her group.

As I explained in the Method chapter, I contacted leaders of all the WLS support groups in the South-West telling them of my research and asking if they were prepared to participate. Tracey was the first to reply in an enthusiastic e-mail and we quickly arranged to meet at her home. I was struck by how stylish and immaculate her house was; the number of recent studio photographs of herself and her partner hanging on the walls; and the enormous chairs, clearly a relic from the time when she was very large. She was a size twelve to fourteen and it was hard to imagine her as big enough to qualify for WLS. She had to have the surgery privately three years previously, despite having Type II diabetes, sleep apnoea, joint pain and high blood pressure, because she had 'only' weighed eighteen stone (114.5kgs). She chose to have a LAGB rather than a bypass. Tracey gave me a leaflet she had written telling the story of her struggles with weight, her choice of surgery, and life after it.

4:4:1 *Taking control*

Preparatory to beginning the interview I gave her the consent form to sign and my information sheet. I said I was interested in the patient's point of view because there is little in the literature that looks at this. The sheet also expressed my wish to know about what had happened to the desire to eat and I added verbally that I wondered about the experience of hunger.

1 T: *what would you like to know?*

2 J: everything

3 T: you'd like to know everything

4 no you you give me some prompts (J: um)

5 and I'll talk

6 J: well I suppose your your your leaflet will tell me wuh-

7 T: *what is it you specifically want to know*

8 J: I'm interested

9 T: hunger before surgery

10 or hunger after surgery

11 J: I'll tell you why

12 T: yes go on

13 J: I did a focus group for Dr Charlotte who's the

14 T: {yes, yes

15J: psychologist at X hospital

16 T: {yes, yes

17 J: and the people I spoke to

18 were all relatively recent ah bi-band people on the

19 T: {mm mm

20 J: bi-band research and all they could talk about was food

21 but that kind of prompted it

22 T: right

23 J: but I'm also um

24 the professional

25 the academic literature

26 T: {there's very little

27 J: almost nothing

28 T: there's very little written

29 I've found one book about gastric bands (J: right)

30 I found some information on the internet

31 but uh some of it was very negative (J: yeah)

32 which I refused to read (J: right)

On the recording Tracey is brisk, almost impatient, not giving me time to finish my sentences. It was the first interview I had done and I felt flustered and foolish in the face of her questioning. She had turned the tables on me and taken

charge. I tried to re-establish what I clearly considered to be my position by mentioning my connection with the WLS psychologist – appealing to a higher authority - and referring to the literature, at least I could rely on my academic credentials! Tracey comes back at me quickly to show that she too knew the psychologist and was familiar with the literature, thus putting me in my place. I was aware of my emotional state at the time and that Tracey was placing herself in a superior position in the interview, but it was only on analysing the transcript that I saw the manoeuvres *I* used to try to re-establish what I obviously thought was my 'proper' position.

In the next excerpt Tracey gives an account of therapy she had some years ago and, as a clinician, I can imagine she did everything she could to manage her sessions. I felt it in the interview as well – we were not having a conversation, there was little reciprocity, and my turns consisted largely of continuers. (I am not suggesting that it should have been any different, rather I am noting my discomfort.) As one woman meeting another it was uncomfortable; as a clinician it was a challenge (not to be taken up); and as a researcher it was fascinating to think about how she achieved it.

43 T: *if the subject of my weight ever came up*
44 *I always closed down*
45 *so it was kinda like it was a taboo subject*
46 *you could be my friend*
47 *you could be my best friend*
48 *but don't ever mention what I look like*
49 *'cause then I really won't be your friend*
50 *I'll be quite hurt (.h) (J: yeah)*

Another example of her taking control was her description of her first visit to the private hospital to arrange her surgery:

107 T: I told them what surgery I wanted
108 and (J: huh huh) they said hang on a minute

109 let's look at all the different surgeries

110 let's look at your options (J: right)

111 and but I'd already decided so

I remember that when I gave that little giggle [108] I was thinking they did not have a chance in the face of her determination.

After the opening interchange, I said nothing but 'right' and 'yeah' for the next quarter of the interview then, when she said that she was not sure of her current BMI, I attempted to join in with a comment of my own responding to the fact that she was what is considered a healthy weight, but she talked straight over me:

428 T: but I can go out

429 I can run right ok so yeh

430 J: mhm-hm huh you really are not

431 T: Um

432 J: we make much too much fuss I think about

433 T: {so after fourteen months that's it

434 it's stopped

435 J: and how do you live with that

436 T: aah ok so-o

437 what I tell people is

I tried to join in again by asking a direct question [435] about her experience – then she did respond to me but only by giving me the answer she gives to her group members. So I was relegated to the status of one who needed to be informed [437] and attention was diverted from her own experience. A further attempt to join in [744;746] was talked over by the simple expedient of Tracey raising her voice and carrying on as though I had not spoken:

720 T: you suffer from a thing

721 we call it fat-head (sniff)

722 fat-head erm it's it's body dysmorphia (J: yeah)

723 when the body and the mind

724 erm it takes

725 it takes the mi-ind quite a while

726 to catch up

727 the mind and the body um

…

740 so a fat-head is erm one of the things

741 another thing

742 I found very little written about body dysmorphia

743 um and and

744 J: yeah it's always related to anorexia not

745 T: {ye-eah and

746 J: about being large

747 T: {you know so there there was little written about that

Clearly Tracey and I were working from different models of what interviews are. I had hoped for a conversation about her own experience of the surgery and its effects, combined with the extra knowledge she had gained from running a support group. Instead she gave me a demonstration of what she tells her group - which often diverted attention from her own experience.

4:4:2 *Transformation*

When she did talk about her own experience, it was rarely in the first person. She emphasised the transformative power of WLS, but only if it is worked at - success does not come easily. As reported by Scholz (2009), Stinson (2001) and Wolf (1991) in their research into dieting, she used the language of religious revivalist meetings in which heaven and salvation are being described as attainable if the straight and narrow path is followed.

285 T: we're now starting to feel better about ourselves

…

361 T: but now you start to do different things

362 life becomes more interesting
363 you start to laugh more
364 or you're happier
365 you feel better about yourself (J: m-hm)

Tracey's use of a generic 'we' and 'you' make her descriptions appear to be fact, unquestionable, simply what happens. (Wiggins2009) In these moments of talk she is building a glowing picture of "life after weight loss surgery": it is a testimonial, not only for the effectiveness of the surgery, but also for herself as someone who has been successful at it.

At other points she talks from a different position, one where she emphasises the effort required to make a success of WLS, but again showing that she has been prepared to make that effort and the results have been worth it.

424 T: everything I've ever wanted (.)
425 as regards weight (.) has happened

681 T: in life there is no such thing as a miracle
682 but this comes pretty damn close
683 this is as close as you're going to get you know (J: mm)

934 T: it's a price to pay
935 but it's been worth it a thousand times over

She has been transformed, not just physically but mentally as well. By using language which emphasises the near-miraculous [681;774&776p108) effect of her surgery and underlines the high price [935] she has paid, she conveys a sense of the enormity of the transformation. Through sheer hard work she has lost weight and in the process gained a sense of her own worth. She establishes an identity for herself of someone who, by shedding the pounds, has shed the person she was, and become someone better. This emphasis on things that have

a high price and which require hard work to acquire is an appeal to Protestant capitalistic values – Tracey has made her virtue visible.

156 T: I happen to think now
157 I'm worth more than that
158 and I'm worth better than that
159 because I've raised the bar
160 I've raised the level of my life (J: mm)

203 T: life's brilliant you know
204 every day to me now is party you
205 you know I go out
206 and uh I don't know
207 I might go and decide to buy a balloon
208 and have a walk down the sea wall or something
209 because I can (J: mm)

The image of raising the bar contrasts her former low-life character with a new person whose eyes are on higher things: who does not sing drunkenly at a karaoke night, but buys a balloon and walks on the sea wall – a return to pure, childlike ways of being.

648 T: life beyond weight-loss surgery
649 is about never having to diet again
650 because your mind-set has now changed

But, it is living on a permanent diet, eating off a tea-plate with a teaspoon so as to avoid the painful side-effects of eating too much, which does not conform to any semblance of 'normal' eating. She transforms this from an unusual or abnormal form of eating by presenting it as a product of a changed mind-set which accounts for it as a matter of choice.

772 T: I look in the mirror some days

773 and I think you know

774 that is a miracle

775 I'm still thin

776 it's a miracle

777 this is amazing (J: ok)

And I have to agree – it is amazing for someone like Tracey, (and all the other people I interviewed), who had struggled all her life with yo-yo dieting and now had found a way in which, for the moment at least, to stop the bounce-back to old eating patterns and inevitable weight increase.

Integral to the rhetoric (Billig1987) of a story of transformation there has to be a 'before' as well as an 'after' set up in opposition to each other - whether the 'before' was her previous self, or the contrast with others who had not lost weight or worked at maintaining that loss as she had.   In the process, like most of the people I talked with, Tracey demonstrated her loathing of fat, othering her former fat self and anyone who was still large.

The following is set in contrast to her depiction of her current self as "I'm so busy I'll forget to eat".

783 T: and large people are always very busy

784 they're always very busy

785 they're always very loud (J: mm-hm)

786 um they're always busy

787 but actually when you listen to them

788 they're actually doing bugger all

789 they're actually doing nothing

790 but they have their own

791 own sense of importance

792 I was always the first one

793 who was drunk at the karaoke

794 singing very loud (J: mm)

795 and when I think of it now

796 I absolutely cringe (J: mm)

Tracey is building an image of her transformed self by painting a contrasting picture of a shameful, stereotypical, larger-than-life fat person in her former life.

856 T: I don't like being a loud person

857 I don't like being an extravert

858 the person who I've discovered

859 I'm actually an introvert (J: right)

860 but yet as a large person

861 who used to eat everything

862 I probably came across as being extremely gobby

863 and extremely loud (J: yeah)

…

868 I look at larger people at karaoke

869 and I walk the other way

870 I enjoy singing

871 but it's something I would never ever do again (J: yeah)

872 erm getting drunk and I'm disgusted

873 because I realise that is not me (J: yeah)

It was painful to hear this level of self-loathing – even of a former self – but it suggests that she was setting up an extreme version thus highlighting the changes she had undergone, and emphasising the transformative power of WLS.

Sitting on a chair in a furniture store, breaking it, and then having to be hauled up by two salesmen, was a story she told to illustrate one of the significant moments in her journey to getting surgery. I had expected to hear more stories incorporating such turning points leading to a decision to have WLS, but hers was the only one – perhaps because she had her surgery done privately whereas the others all had theirs done on the NHS and the decision was not so clearly in their own hands.

1039 T: when I broke the chair

1040 I was disgusted with myself

1041 I was absolutely disgusted

1042 but even that didn't stop me

...

1064 I was annoyed with myself

1065 for allowing myself to be a mess for so long

Tracey's use of words like "cringe", "disgusted", and "mess" are so visceral. Using them demonstrates her adherence to the discourse which depicts fatness as physically abhorrent – fat as ugly in itself, to be avoided on the person or in food.

4:4:3 *Fattist talk*

This disgust carried over into her talk about the people she came into contact with in her support group and for whom WLS had not worked. She was often scathing, depicting them as irresponsible [222], not prepared to put in the work or to take responsibility, but passively expecting the weight to magically disappear. This was a theme picked up in almost all my interviews and clearly shows the shift noted by Willig (2000) from the nation state having responsibility for health to the neo-liberal discourse of personal responsibility.

217 T: take responsibility for yourself (J: uh-uh)

218 what's your band fill (J: uh)

219 don't know

220 how much fill did you have in last time

221 ooh I don't know

222 they're not responsible (J: uh)

223 that's a key

224 that's a key (J: right)

By using the device of direct reported speech here she is presenting 'what was said' as factual proof of her judgement of the individual in question. It also dramatizes the story, making it more vivid. Holt says that it is "…associated with contexts when providing evidence of what a speaker said is particularly important, when, for example, one is complaining about what someone said or disagreeing about a previous utterance, or when trying to depict in a series of utterances the stances of the reported speakers through the quoted talk." (1996 p242)

672 T: in the majority of cases I've come across
673 they really don't know (J: yeah)
674 they're not taking responsibility for themselves (.h) (h.)
675 they know that what they have is a tool
676 and a tool to do a job
677 but they expect
678 that they don't have to make any effort (J: mmh)
679 they think that it's somehow going to be a miracle
…
684 the band hasn't failed you
685 but you may have failed your band (J: yeah)
686 is is what I maintain
687 you have to make a little eff -
688 only a little bit of effort
689 but it's not difficult (J: mm)

948 T: and I've seen people talking about surgery
949 and I've seen people saying things like
950 ooh well when I get my surgery
951 everythin' will be sorted out
952 and I've turned round
953 and I've said no
954 because you have to change
955 until your mind-set changes

956 and until you

957 you come out of denial about yourself you know

958 and it's no good turning round

959 as a thirty stone (190.5kgs) man once did

960 and told me he eats nothing but fruit and veg

Yet despite all this disgust at fat and fat people, Tracey also expressed herself to be in a quandary – was she still the lazy, stupid [1121p113] person who is part of the cultural narrative of fat people, even though she was no longer fat? Had she shed the stupidity with the pounds, or was she still the same person? Taylor & Littleton (2006) emphasize the constraints upon the establishment of a new identity produced by previous tellings. In this case the constraints also came from Tracey's descriptions of people who were currently fat in the sense that they were also accounts of her past self thus troubling her new identity. What follows is a demonstration of her awareness of the contradictions and inconsistencies, tolerable and intolerable, in her narrative which require some thought, explanation and repair.

297 T: you walk past workmen who

298 who wouldn't have loo-looked at you

299 all of a sudden they're smiling and waving

300 and you're thinking you know

301 sometimes I think well you know what

302 you couldn't look at me before

303 then well whatever

304 but things change

305 life should be the same for everybody

306 but it's not (J: no) unfortunately

804 T: how do I look

805 do I look like a fat person

806 do I look like a thin person

807 sometimes I don't know (J: yeah)

808 sometimes I'm not a hundred percent sure (J: yeah)

809 yeah if I'm a thinner person

810 do I look more intelligent

811 I'm I'm the same (J: yeah)

812 I'm the same in here as whatever I (J: yeah)

813 you know I'm eleven pounds overweight

814 when you meet me

815 do you see somebody who is eleven pounds

816 no-o of course you don't

817 so I-I don't know

Reflecting on once being asked by someone if she would have a de-fill of her band so that she could go back to "normal" eating, her response was that it was "so-called normal eating" that had got her into this position in the first place. She then talked of her fear of going back to her "old ways" and said that she was not "prepared to risk it (a defill)". So, for all her talk of loving herself now, of having "raised the bar", and changed her "mind-set", she also illustrated fear of another failure and regaining all the weight.

And, as a final sad coda, she positions herself back as the fat woman who was insulted from within the cultural 'knowingness' (Murray 2005) about the meaning of fat bodies:

1118 T: I'm an average woman in a street

1119 slightly above average IQ

1120 I know that 'cause I had an IQ test once

1121 because somebody told me once I was stupid

1122 'cause I was fat and stupid you know

1123 whatever what gives them the right to say that I don't know

1124 but there you go

1125 they think that larger people are easy pickings I suppose

4:4:4 *In summary*

Tracey is an example of how the group leaders in particular took control of the interviews mostly by a flood of talk. I rarely had to prompt people - the problem was more one of getting them to remain focused on their surgery and its aftermath. I found that analysing the interview with Tracey was useful in that it was not just the force of the flow of her talk that was striking, but also the subtle changing of positions which was evidenced in her ideas about how she had been transformed by WLS. This involved her in a process of 'othering' both her former fat self and current "big people", but it appeared to leave her in a position of not knowing where she fitted. She oscillated between still being a "big person" who is currently slim, and disowning the large person she once was, claiming her slim self as the "real me". I chose to focus on her because she made the complicated 'trouble' in identity work (Taylor&Littleton2006;Taylor2007;2015) so explicit. Despite all her claims that she had changed her "mind-set" and had dealt with all the difficulties which had caused her to overeat in the past, she also expressed doubts about the depth of the changes.

4:5 *"That's so not me" - Monica*

I chose to write about Monica as an exception because she described the kinds of difficulties after WLS which I had expected most of my interviewees to mention. To my surprise hardly any of the others talked about them. In this section I will only discuss those parts of Monica's interview where she differed from the others. She was not a complete exception - there were things she shared with other interviewees such as her joy at being able to be more physically active.

Monica and I met at a support group during which she said she was finding it difficult to adjust to the changes she had gone through since her operation. No-one responded to this and the conversation, which was about how to follow the post-surgery diet, continued as though she had not spoken. She approached me as soon as the meeting was over saying that she would be happy to participate in my research. I contacted her some weeks later and got a warm response. As

with my other interviewees, I offered a choice of venues in which to meet and she suggested the café of a supermarket in a town local to her.

She is a single woman with adult children, all of whom are, according to her, "big kids". Her talk was of a life in which there was lot of involvement with her extended family – the members of which she described as "big people". She is about five foot five inches (1.65m) tall, and before surgery had weighed twenty seven stone (172.5kgs). When I met her, four months after her operation, she weighed sixteen and a half stone (105kgs). In response to my opening question about the experience of WLS she began with a description of her ten year journey in search of a solution to her problems with yo-yo dieting and ever-increasing weight. Like some of the others, her surgery had once been cancelled at the last minute and she talked about her resulting desperation to get it done. The level of hope invested in the surgery, not just of transformation but also of being freed from the complications of morbid obesity, makes the fairly frequent cancellations particularly difficult to manage.

4:5:1 *Struggling to find herself*

Monica talked about not knowing who she was after such rapid weight loss; the difficulty of adjusting to the change in her size; and of not being sure she liked it. In Taylor & Littleton's (2006) terms she was a "novice" in her new identity as a much smaller person and it was as though her old identity [377] had disappeared with the weight, leaving her bereft.

372 M: I'm really struggling to find myself (.)
373 because it's almost like
374 it sounds really bizarre
375 but it's almost like
376 when I was big
377 I fitted in the fat club

Discourse analysts suggest that identity is constructed in and through social interaction and is "…often defined in terms of who we are not and who we are similar to." (de Fina2012p271). (Harré&Gillett1994;Wetherell&Edley1999; Wetherell2008). The surgery takes place in the context of a person's life and for this woman, coming from a "big" family, the massive weight-loss made her visibly different, setting her apart from them. Also, she could no longer comfortably participate in communal meals because of the restricted capacity of her stomach which could lead to painful dumping. Monica vividly expressed the difficulty of adjusting to the rapid changes in body size brought about by WLS and of inhabiting that new body. She was, quite literally, half the woman she used to be and appeared to be struggling to find a way in which to negotiate an identity and to position herself.

On a number of occasions she said that talking about this experience of not knowing who was this new, thinner person sounded "bizarre" (9x), "weird" (6x), "crazy (1x)", or "strange" (10x). In the rest of the interview she often apologised for a thought she had tried to express, diminishing it in the manner just illustrated or by saying such things as "…sounds really stupid dunnit weird…". ([2204]p125) This could be heard on many different levels: (i) that she was apologising to me as an older middle-class 'researcher from a university' as though she could not be up to my standard and perhaps even, should not have the temerity to think outside of her class or gender position; (ii) that she was trying not to sound ungrateful for having received free WLS; (iii) that she was referring to the value placed on being thin and might appear to be rebelling against cultural norms if she expressed difficulty with weighing less; (iv) and/or that she was giving voice to her own confusion in the light of the three previous points.

378 M: and when I lost weight
379 I thought I'd immediately be this new person you know
380 with no kind of effort
381 I've just lost weight
382 and I'm still Monica you know

This section illustrates the power of the transformation fantasy/narrative many writers describe. (Maor2013;Salant&Santry2006;Throsby2008) Folk tales, magazine articles, social media, and television programmes thrive on this, whether it's Cinderella, garden make-overs, house renovations, or weight-loss. This was evident in all the interviews I conducted and, as is the case in fairy stories, the protagonists are meant to 'live happily ever after'. But, when Monica expands "I lost weight" [378] into "I've just lost weight" [381] - in the sense that that is all that has changed thus diminishing the importance of the weight-loss - she highlights the loss of knowing of who she is. Her embodied self was completely changed and she had yet to create an accommodation with her new physical form.

383 M: but I've completely lost myself
384 and who I am
385 and where I am
386 what I'm doin'
387 where I'm goin'

These last four brief statements highlight the comprehensiveness of the loss – their brevity emphasising it.

505 J: this is why I'm doing this research
506 this is exactly why
507 because of what you've said
508 you hadn't realised how hard it is
509 M: no
510 J: and people just don't realise how hard it is
511 it's physically hard but it's emotionally hard
512 M: {emotionally worse
513 J: and that's the bit that just gets it (indistinct)
514 M: I can't
515 I can't look in the mirror

516 or see myself in a window and think ooh

517 I just can't do it

518 I look in the mirror

519 as I see my reflection at home in the doors or what ever

520 and I'm like that's so not me

521 'cause all my life I've been the big me y'know

522 I've been the big girl (J: yeah)

523 big bubbly you know (J: yeah)

524 but there's this wall up

525 that nobody actually gets through y'know (J: yeah yeah)

526 and now all of a sudden

527 I feel a (indistinct) vul-vulnerable

528 o-oh it's strange

1973 M: I haven't got any photographs (J: yeah)

1974 I haven't took any on purpose

1975 I don't like it (J: yeah)

1976 I didn't like it before (J: no)

1977 I've got a few

1978 that they've managed to catch over the years (J: yes)

1979 but I've not had any since my op (.)

Monica describes how the loss of her protective layer makes her feel vulnerable [527] and she talks as though she cannot bear to see that, so she does not look at her reflection or photographs of herself. She says she does not know who she can be anymore now that she can no longer play the role of the big jolly "girl", a safe and recognisable character which fits neatly into the stereotype of 'what fat people are like'.

Another aspect of the problems Monica was having with her perception of herself was due to the side-effects of the surgery. When describing a visit to the nurse at the hospital she said:

729 M: um and I mentioned things to her

730 like you know (.)

731 sounds bizarre

732 but tucking your boobies in your bra

733 because your bra is w-w(.h)ay too big

734 you could probably tuck them

735 (.h)und(.h)er your (.h)armp(.h)its you know

736 and she just laughed

737 which you know

738 which she would (J: yeah)

739 but maybe I didn't come across

740 I wouldn't say desperate (J: no)

741 um so to her

742 as if it wasn't a problem y'know

743 maybe I should've um

"Sounds bizarre" appeared to be a way of qualifying, or apologising for, what she was saying. Her use of "boobies" as a noun for her breasts is partly a common usage, but it also conveys a childish image which suggests a humiliating situation. She conjures up a funny picture in this troubles telling (Jefferson&Lee 1981;Jefferson1984a), using humour to disguise her difficulty around this issue, but it was one she returned to. In this context Monica shows her awareness that using laughter when talking of painful things can backfire when the trouble was not taken seriously. [739-743] Jefferson (2004) discusses differential reactions of women and men to laughter in troubles telling and distinguishes between "trouble receptive" and "trouble resistant" responses. In the instance Monica describes, her auditor falls into the latter category. This was not uncommon in the interviewees' reports of the reactions medical staff made to talk of problems with WLS. Four interviewees reported that they felt staff only wanted to hear the good news and would shift the talk to the remarkable amounts of weight that had been lost, thereby making a "step-wise transition" from the troubles telling (Jefferson1984b).

808 M: I noticed that my hair is fallin' out

809 I had it cut off

810 I've had it cut since I saw you (J: mm)

811 um it's all really really fallin' out

812 and I used to have lovely long nails

813 and they're all broken

…

840 my hair fallin' out it's not good (.)

841 it's weird isn't it (.)

…

858 but nobody tells you

859 about your hair or your nails   (J: right)

860 and for a girl that's quite important really

861 J: seriously important

862 M: I know huh huh huh

863 I was a bit horrified

864 I was sort of brushin'

865 and thinkin' god

Although she said elsewhere in the interview that she had never put herself "out there" sexually, or even regarded herself as attractive, this loss of hair and nails seemed emblematic of a loss of attractiveness as a woman [860]. I have to note here that she referred to herself as a "girl" throughout and I could see that as a typical example of female self-denigration fitting in with the wider discourse which devalues and infantilises women, but it can also be seen as her treating me with some familiarity, as 'girls together' talking about 'girl's stuff'.

4:5:2 *Food* **-** *"it's just like munchin' cardboard"*

I had also expected participants to report a significant change in their relationship to food because, after the bypass and the sleeve, the sensation of hunger is often lost and the taste of many foods alters for reasons which are not entirely clear. Also the effects of the physical restriction can be sufficiently dramatic to

make eating feel like a risky business. During the course of the interview Monica gave nine examples of how she had always used food to "fix" uncomfortable emotions, the difficulty post-WLS was that this no longer appeared to work even though she continued on occasion to do it "because of habit" ([2143]p124).

What follows are six extracts from the interview in which Monica described her lack of hunger, an experience of dumping, and how the taste of foods had changed. I expected most of my interviewees to express some difficulty in coping with three such major changes as these in their relationship with food, but other than Monica, none did: if anything they expressed relief at eating being made difficult, in that they hoped this would enable them to maintain their weight-loss. She talked with pleasure about the freedom to move and do things which losing weight had given her, but as described above, she was feeling that she had lost the self she knew.

787 M: I-I will say I'm not hungry
788 I haven't felt hungry
789 since the day I had the op
790 seriously not hungry
791 but I find that strange too huh huh
792 that's when I look at the clock
793 ooh it's half past twelve
...
796 but I know I'm not hungry at all
797 food no longer
798 doesn't give me a boost or anything (J: right)
799 it's just eatin'
800 'cause it's what I need to do (J: right)

In this piece she is describing two different things. The first is the complete loss of the sensation of hunger. Her physiology has been altered to the extent that she no longer gets prompted to eat either by feelings of emptiness in her stomach, or by thoughts of food. The second is that there is no pleasure to be

had from eating because it does not perform the function that it once did through pleasurable tastes and textures.

1806 M: it's really difficult
1807 to find things that you can eat
1808 that you should eat (J: yeah)
1809 and you actually want to eat

This succinctly sums up her dilemma – her body is not giving her the normal cues to seek food; there is a risk of dumping if she eats the wrong food at the wrong speed at the wrong time, and none of these is predictable; she is hedged around by dietary advice from the WLS service; and the food when eaten gives no sensual reward – so eating becomes a chore.

2059 M: physically you can't
2060 you can't eat like you did
2061 and if you do
2062 you're sick
2063 you're ill
2064 and that takes a lot of
2065 I mean I only did that the once
2066 that really made me think
2067 I'm not doin' that again
2068 in fact if I'm honest it frightened me (J: yeah)
2069 I really seriously thought
2070 I was gonna have a heart-attack (J: yeah)

Monica's shift from "you" to "I", and the use of direct reported thoughts in the above adds an emphasis and a persuasive veracity to the account. She also described an occasion when she had uncontrollable diarrhoea at work and another when she was out and had to vomit in public. These experiences made her fearful of eating and the incredible rapidity of her weight loss suggested that she was eating very little – she said it was between "six and eight hundred

calories a day" [1438]. After telling me this she went on to talk of a friend who had become anorexic after surgery and would only eat Wotsits.

I have included the following section almost in its entirety because I have had a real struggle between the sense I made of it at the time in the context of the whole interview, and what the words actually appear to say when read in their own right. I will attempt to explain this below.

Monica was talking about some of the complications that the surgery had introduced into her relationship with food and eating.

2124 J: have you found
2125 that your tastes have changed
2126 M: yes yeah nothin' tastes the same as it did (.)
2127 probably to be honest
2128 even chocolate doesn't do it now (.)
2129 not now (.)
2130 I think it's because maybe y-
2131 this is going to sound really bizarre
2132 maybe you needed the emotions in your head
2133 you know the teasy [1] upset anger whatever (J: yeah)
2134 to make whatever it is that you're eatin'
2135 taste the way it tasted (J: yeah)
2136 if that makes any sense at all (J: yeah)
2137 but now
2138 because you know
2139 I mean I know now in my head
2140 that I don't really want that chocolate
2141 and I don't really need it (J: yeah)
2142 now
2143 because I have it out of habit
2144 rather than y'know fear anger frustration or whatever

2145 it tastes different (J: yeah)
2146 that sounds really stupid
2147 but it is it's true

In this section she appears to be conflating not having the desire to eat chocolate with not experiencing emotions like fear or anger. She also appears to be saying that having those emotions had added savour to the chocolate – or even created it.

2150 M: I think what you need
2151 is a place in your head (J: yeah)
2152 to binge on the food
2153 for that food to make you feel good
…
2156 and when the head has changed (J: yeah)
2157 the habits have changed
2158 and so the food doesn't taste the same

"When the head has changed" – does that mean the emotions are no longer there, or does it mean that the knowledge that the chocolate will not taste as it did before has changed her thoughts about it and therefore her urge to eat it? I am aware of my own struggle to make sense of this partly because the changes in taste which occur after WLS are a well-documented aspect of the physiological response – but change in taste does not mean that emotions disappear too – I am also wanting to impose a coherent narrative where perhaps one does not exist.

2173 M: and there's nothing I (.) crave (indistinct) huh huh (J: yes)
2174 it's bizarre (J: yeah)
2175 the whole mind set is different (J: yeah)
2176 'cause I used to eat before when (I) was bigger (.)
2177 not just because I was hungry (J: no)
2178 'cause of everythin' else
…

2196 I have had some sweets

2197 but (.) it's just like munchin' cardboard really

2198 they don't really

2199 they don't satisfy anything

2200 'cause I haven't got anything in my head to satisfy so (.)

2201 they've not taken away

2202 whatever it is I'm eatin' for

2203 so I don't bother (..)

2204 sounds really stupid dunnit weird (.)

2205 I haven't really thought about it before

In this last section she seems to be saying that "whatever it is I'm eating for" [2202] ie. to get rid of negative feelings, will not be taken away, so the "thing in my head" [2200] that used to be the place of satisfaction is no longer there.

As I said above, in the context of the whole interview Monica was very clear that "my head is bursting everywhere" [1690] and that not only did she still have all her old problems, but now she was having to grapple with the issues caused by her massive weight-loss. I have found this section of transcript really difficult to get my head around and have wanted to interpret it as follows: The changes in taste and the absence of hunger have meant that food no longer performs its function in dealing with difficult emotions – but I am not sure that that is what the words say.

I took this section of the transcript to the DA workshop in the hope of getting some perspective on it and it was pointed out to me that I was trying to impose some kind of order onto what Monica said and was at risk of losing sight of, or repressing, the extent of the disruption she was conveying. It was as if I could not tolerate her depiction of an identity which had been thrown into chaos. This highlighted how my emotional reaction to an individual and what was being said affected my capacity to think about it analytically.

4:5:3 *In summary*

Monica had lost ten and a half stone (66.8kgs) in four months and was struggling to find herself in her rapidly changing body and to find a place in her particular world for this new body. Adding to these difficulties were the side-effects of the surgery, from fear of dumping and uncontrollable diarrhoea, to the loss of hair, the breaking of her nails, dry loose skin, and the absence of physiological cues to eat. She was the only person to talk in any detail of the gap left by the inability to eat as she had done before surgery.

4:6 *Conclusion*

I have aimed to give a detailed picture of four people's accounts of their experiences of WLS. I have explored some of the themes which seemed most relevant such as the dreams of transformation, on the one hand passively received through the work of the surgeon, and on the other only attainable by dint of hard work and knowing the rules of post-WLS behaviour. I have also noted how wider discourses such as those of personal responsibility for weight gain or loss; healthy eating guidelines; or disparagement of fat people were evident in the talk of my interviewees. I looked at the complicated identity work involved in the shift from being a very fat person to one who is losing weight rapidly. What was noticeably absent was talk about the meanings food might have – all talk about food, with the exception of that of Monica, was literal and concrete and confined to the dietary rules being followed; details of changes in taste and texture; or what might precipitate a bout of dumping. I will discuss these issues in the next chapter.

Note

1 "*Teasy*" is a colloquial expression of irritability.

Chapter 5: Analysis Part II

This chapter is based on my transcription of the content of the interviews into stanzas (Gee1999) comprised of a single or unitary idea. Below is a discussion of what arose most frequently or seemed most pertinent to the dominant discourses around the causes and cures of overweight. I will explore how weight was accounted for; where responsibility was described as being situated; how shifts in time in the participants' accounts dealt with 'trouble' in attributions of responsibility; and the role played by discourses of transformation and rebirth. I will also look at evidence of anti-fat prejudice in the talk of interviewees and at the concrete nature of their approach to food. None of the areas I focus on are mutually exclusive and, as discursive strategies, tend only to be effective when used in combination.

5:1 'Trouble' for the Neo-Liberal Subject when Dealing with Issues of Agency, Control, and Responsibility for Overweight

My interviewees were in an anomalous position with regard to the current discourses around weight and health. In order to avoid criticism for being irresponsible in relation to the neo-liberal requirement that we all take care of our own health they had to find reasons, which I will discuss below, for their overweight which were external to themselves and thus absolved them of responsibility for their size. There is another discourse (Knutsen et al 2013;Radcliffe2013;Throsby2007) which blames fat people for taking more than their share of available resources so, not only are they at risk of being criticised for eating and drinking too much, when they have WLS they are open to charges of undeservedly taking scarce NHS resources. As I will describe below, a number of the participants showed their awareness of these accusations. (Hannah [296]p99&[1312-1326]p100]). In dealing with this 'trouble' they defended themselves through chronological shifts in their accounts from their pre-surgery selves to the transformed after-surgery person they would be or had become.

5:1:1 *Externalising responsibility*

The participants tended to respond to my question: *Tell me about your experience of WLS?* by explaining the need for surgery through emphasising their lack of agency and externalising the locus of control of their eating to account for having become severely overweight. They positioned themselves as the subjects of circumstances rather than as active agents in them, therefore they needed WLS as an externally-applied solution.

MacAvoy talks about the privatised, individualised, neo-liberal self as always being on the "border of failure" (2015p26) particularly in relation to the control of the body for which it is seen as entirely responsible. This was evident in aspects of my interviewees' accounts of their pre-surgery lives. They all told of endless attempts to lose weight, and most had lost and regained startling amounts, always ending up larger than when they started. (Dalloo,et al2012;Hill 2004). This phenomenon has been well-documented (Garner&Wooley1991) and they described this inexorable increase in size as happening *to* them and therefore as being beyond their control.

5:1:2 *Shifting between passive and active through time*

The language used to describe this process of losing and regaining weight was so passive that it conveyed a sense of it 'just happening' to them. It was a description of their helplessness despite having put enormous efforts into losing weight – they all reported having tried a range of treatments - jaw-wiring; drug treatments such as Orlistat; and attending slimming organisations. An identity was being built of someone who had worked hard to gain control of their weight, and this account of themselves would be carried into the future as they dealt with WLS. They demonstrated having tried everything in order to escape the accusation of taking the easy way out by having surgery. Certainly, to qualify for WLS, it is a requirement that people have tried and failed at all available treatments before they can proceed. This seems obvious, but the patient is regularly reminded that WLS is only a 'tool' which they have to use, so it is not guaranteed

to work without constant self-surveillance. There is a potential mis-match between this official description of the surgery and the belief that it will solve the helplessness described in the face of continual weight-gain. All the failures in the past were accounted for in a way that fitted with this idea of personal effort being required, and the lengthy descriptions of the amount of work put into weight-loss go to build up an identity of an individual who is not afraid of hard work.

No-one said directly that they had overeaten before surgery or that they had not been able to get control of that. Ten did say that now, when out for a meal, they could see *others* over-eating and some said that they realised that it was what they *used* to do – thus distancing themselves both in person and in time. It seemed as if it was easier to talk about the eating habits of others than to talk about their own. This silence about, or repression (Billig1999**)** of the possibility that they had eaten too much prior to surgery indicated a taboo: instead their weight–increase was accounted for in terms of factors beyond their control. To suggest that they may have over-eaten would lay them open to the accusation of being greedy and therefore morally reprehensible. (Maor2013;Throsby2007/8/9;Wiggins2009).

5:1:3 *Addiction to food*

Of the reasons offered to explain overweight, food addiction was a common one:

602 J: it's when you can't eat the way you (indistinct - would have done)
603 it's what do you fill the gap with
604 George: yes yeah
605 J: you're saying well thoughts are turning to X (a drug)
606 G: thoughts are turning to X
607 and also um (.)
608 (shopping) huh huh is another addiction

When George talked about missing being able to eat bread:

666 G: so you do miss those things
667 and you do have to replace it somehow (J: yeah)
668 I mean um yeah i-it's addictive personality

Tracey talking about going to slimming organisations and losing weight which she promptly regained:

121 T: but it doesn't deal with food addiction (J: no)

473 J: (indistinct – it's great what) you've done
474 why couldn't you do it before
475 T: why
476 J: why can you do it afterwards
477 T: right why why couldn't I do it before
478 was because I was always hungry
479 I was always hungry in my head
480 because (.) I hadn't dealt with food addiction

510 T: food addiction is a strange one
511 because it moves around
512 I-ya I pretty much think now
513 I'm not a food addict
514 but then it manifests itself in different things (.h)
515 for example I started shopping
516 so then you've got to watch that
517 then I
518 then it moved around again
519 it was perfume buying
520 then it moved around
521 and again it was handbag buying (.h)

1650 Anne: you know what addicts do

1651 when they can't get their fix

1652 they swap it for something else

1653 and mine is the beauty salon

1654 I spend a fortune there

In this narrative, food addiction shifts to other things as if it has its own agency and is out of their control. Once again, the current discourse around obesity blames those who are fat for refusing to take responsibility for their actions, and this was evident in the talk of my interviewees as well. So on the one hand they would blame themselves if they regained weight in the *future*, and on the other were accounting for their overweight in the *past* in terms that were independent of their own volition thus absolving themselves of guilt for having committed the sin of greed. Trouble, in the sense of contradictions in their accounts, was overcome by shifting the time period in which each situation arose.

5:1:4 *It's in the genes*

Many had recourse to 'It runs in the family' in order to account for their problems with weight - whether it was genes that were to blame for their addiction, or the eating habits they learnt as children. Throsby (2007) received similar reasons accounting for overweight.

I asked George:

718 J: (.) so you when you say addictive personality

719 do you do you feel that it's something you're stuck with

720 or do you think there might be some causal factor

721 G: tse um

722 J: some gap that you want to (indistinct - fill)

723 G: tse my thinking uh ah

724 can addictive personalities be hereditary

725 'cause my father um he wasn't a drinker

726 but he was a spender

727 (.h) um my two (siblings)

728 u-um tse one u-uh one do-

729 one died

730 because … was an alcoholic

731 (.h) and the other one is a drinker u-uh (J: right)

732 so I don't know whether it is

733 y'know in a-

734 in our genes to be

735 to have that addictive personality (.h) um

780 Margaret: but I don't think it was necessarily (.) habit

781 but .h I I put it down to genes

…

1397 um yeah so I think the the gene

1398 I think came from my father's side (J: right)

Others talked of the habits they had learnt – Kevin had a West Country mother who fed him clotted cream, and bread and dripping; Monica was given home-made bread and cakes to keep her occupied when mother was busy with a new baby, and she came from a family of huge eaters; and Nichola was brought up on a farm where there was plenty of rich and fatty food.

5:1:5 *What sort of control?*

Ogden et al, using IPA, argue that their participants "paradoxically" gained "…a renewed sense of control." (2006p273) as a result of WLS. They suggest that in "…hand(ing) over control to someone or something else." (ibid.p280) people felt more in control. Of the people I met, Hannah was the one who was most explicit about this saying: "it was giving me the control back". (4:3[1319]p93) And in relation to the possibility of overeating: "now I don't have a choice" - she was no longer under its control. Ogden et al suggest that the surgery relieves the individual of a feeling of responsibility for the continuing fight with themselves over eating and weight, and for some it "…reflected an internalization of control resulting in a new psychological state." (ibid.p290). None of my participants

expressed themselves in such terms, they all talked of "the restriction", i.e. the actual physical changes produced by the surgery, being the difference. WLS is an admission that one does not have control over one's body and what is put into it, which is a morally reprehensible position to be in, so to claim that the surgery has given the control back, would be to position oneself as above criticism.

This particular notion of control was facilitated by the fear of dumping – although for some it was not a sufficient deterrent:

407 Susan: while I'm eating
408 or I drink too soon afterwards
409 I will get (indistinct - dumping)
...
416 but I live with it
417 and go on to something else

Claudia also found it was not a sufficient form of control:

47 C: when I'm stressed or upset
48 I know what I'm gonna do
49 I know how I'm gonna feel afterwards
50 but I can't stop myself

Of those people who reported dumping, it was not reliably predictable as to what would cause it. It was not a simple matter of avoiding certain foods or ways of eating. In Monica's account (4:5[2059-2070]p123) the experiences were sufficiently disturbing to lead her to limit her intake to what she said was around six hundred calories a day – an untenable situation in the long term. This does not conform to Ogden et al's argument for the "internalization" of control – other than in a very literal physiological sense.

People who become very large are typically viewed as being out of control of themselves and their appetites – specifically in relation to food and drink – and

position themselves to demonstrate that they do not deserve to be judged on moral grounds for their state. Thus my interviewees accounted for their weight in terms of addiction, genes and family culture, rather than the simple greed and laziness attributed to them. The surgery is intended to give them the control they were unable to exercise previously – not as increased willpower, but as a diminished capacity to take in large amounts of food. This raises the question of whose control is being exercised here – is it the individual controlling their consumption or is it the surgery controlling the fat person?

5:1:6 *Transformation or Rebirth*

The hope of transformation was an important aspect of the shifting of time in the accounts. WLS is marketed - in advertising for private surgery, publicly-provided services, internet forums and support groups - on the basis of being a last hope. This feeds into the wider cultural fantasy of magical transformation (Murray2009;Salant&Santry2006;Throsby2008;Young&Burrows2013). Two of the people I met had suffered previously from a major addiction, one being George whom I mentioned above. The other, Tom, had not had surgery yet and was aware that the desire for WLS was a continuation of a pattern which had manifested throughout his life, i.e. the belief that the next thing - whether it was educational achievement, career advancement, relationships, or weight loss – would change everything. "If only I can have this, then everything will be ok." WLS feeds into this kind of hope.

Throsby (2008) writes of the hope of re-birth and transformation, and argues that it is not so much the bodily change from being a fat person to being slim that was significant in the talk of her participants, but rather that she describes them locating themselves as having become "disciplined subjects". No longer objects of the 'war on obesity' but agents, in that WLS is the tool which frees them from the tyranny of weight and enables them to take control of it. Throsby suggests that "the discourse of 're-birth'…signals the reconfiguration of the self as a disciplined subject, who is able to exercise control and restraint over consump-

tion, and who is willing (and able) to take responsibility for the body." (ibid p120)

This was not the sole emphasis of my interviewees – their expressions of being able to stick to the dietary recommendations were tentative and fluctuating, where they talked of being at the mercy of side-effects such as dumping (Anne,5:3:2[540-541]p155) and of needing others to indicate to them when they had eaten enough (Hannah,4:3:1[1180-1184]p87). I would read this as hope, rather than a definite identification of themselves as being in control, that shifted and changed throughout the conversations. For example Tracey (Chapter4:4), who was very vocal in her protestations that she had changed, towards the end of our conversation expressed doubt about how deep the change went in that she would not dare to have the band removed (p114). Maybe she was not the new person she had so vigorously presented earlier.

5:1:7 *Weight-regain - the triumph of hope over experience*

The idea that fatness is entirely self-imposed was in no way a fixed position held by all and at all times – far from it. There was a kind of blankness, an absence, in the way the interviewees talked of how they had become fat in the first place. There was also a shifting of positions as to whether they still identified themselves as large or not, but when the subject of weight-regain came up, their responses were much less equivocal. If they regained weight, then it was up to them to do something about it, and they all had recourse to standard recommendations for weight loss, i.e. diet and exercise. So, what had not worked in the past was being relied upon to work now. I did ask why they thought these would be successful now, but in the end I desisted because I did not see it as part of my brief to challenge them to the point of distress - WLS is a last resort, and if that does not work, then there is no hope.

When talking about the possibility of regaining some weight, Hannah (Chapter4:3) put her faith in the healthy eating and exercise prescriptions which are so prevalent at the moment in medical discourse:

1095 H: I'll have to build up my fitness again I think
1096 um. and then kind of have to.
1097 make some sort of change
1098 up your fitness or something

She reiterated the official recommendations that if her weight were to plateau she must make sure that she does not drink "fizzy drinks" or "eat the wrong things" and "make the right choices" and have "a healthy diet".

1254 H: so uh but I think for me it's more of a
1255 it's a healthy life-style
or Margaret
517 M: that's important
518 just really following the rules

When I asked Margaret what would stop her from putting on weight given that she did not suffer the side-effect of dumping as an aid to restrict her eating, her solution was that fear of regaining weight would enable her to limit consumption by adhering to the official recommendations:

575 J: I I just I'm really interested in the fact
576 that you don't experience dumping
577 M: yes
578 J: that you can eat pretty well anything
579 S: yes
580 J: and I'm wondering how
581 how do you resist
582 if that's the case
583 going back to
584 well the thing that tempts me is
585 I have I have the occasional biscuit (J: yeah)
…

592 and what I'm doing

593 is weighing myself each week (J: right)

...

626 and the minute I see

627 if I start to put on any weight whatsoever

628 I should know

629 I've got to stop the occasional sweet

630 the occasional bit of chocolate that sort of thing (J: right)

631 um so I still am tempted now

632 taking some of the things I used to do

633 um and it's working still at the moment

634 but if that was to go wrong

635 and I started to put weight on

636 I would just go through the whole diet

637 back to basics

638 and just cut out everything I shouldn't be eating

...

659 so if I started to put weight on

660 I suppose that's something

661 that I could work on better than I

662 I do try I do try (J: right)

663 but I find it so hard (J: right)

George similarly hoped that his fear of regaining weight would enable him to keep his eating within the guidelines.

1352 G: (.h) y'know a- and I don't want to

1353 I don't want to (.h) embarrass my children

1354 and and (J: yeah)

1355 I I those are the things that I gotta keep in my head (J: yeah)

1356 those are the incentives that k- y'know don't ever ever ever

1357 even though I was happy

1358 even though I was content (J: yeah)

1359 I didn't realise how miserable I was

1360 I didn't realise

1361 (.h) until you've lost it

1362 you don't realise (.)

1363 what you ha- you have missed y'know

Given that these things had not worked for the previous nearly twenty years, his optimism that they would save him from over-eating, or from returning to drug-use which he said was in his mind, fitted with the transformation fantasy.

5:2 Fattism

5:2:1 *"Well I've always been (.) fat there's no other word for it."* Anne

As I have suggested throughout, the anti-fat discourse in the wider culture (Bordo2003; Boero2012; Campos et al 2006; Longhurst2005; Rich&Evans2005; Simpson2015;Throsby2007/8/9/10/12a;Young & Burrows2013) is so extensive and so insidious that it is no surprise my interviewees gave evidence of it in their talk both in reference to themselves and others. Essential to it is the idea that fatness is self-imposed with sole responsibility laid upon the fat person. This showed in the way they talked about others who had regained weight or about themselves in the event of regaining weight but, as I have illustrated above, was defended against in their accounts of their own pre-surgery weight.

There is in Western culture what Murray called a "negative collective knowing-ness" (2005p4) about fat bodies – we read from the visible amplitude that its owner is greedy; morally lax; stupid; unsuccessful; lazy; undeserving; self-deceiving and non-sexual. When we see a fat person we think that we already 'know' all these things about them. My interviewees demonstrated in their accounts of pre-surgery shame and embarrassment that they had seen them-selves in this way, but in the present they talked about other big people. They were positioning themselves as no longer fat by othering those who were still large, and presenting themselves as 'deserving' in that they were taking positive

steps to deal with their size, as distinct from those who were not trying to help themselves.

5:2:2 *Undeserving*

It is a common finding (Radcliffe2013;Throsby2007) that people who have had WLS describe feeling as though they did not deserve it, and that they should have been able to lose weight, and maintain that loss, through self-discipline, diet and exercise. Although interviewees' accounts of how they came to be large tended to externalise the responsibility, thus absolving themselves of the stigma of being lazy and greedy, when they talked about being able to have WLS on the NHS they expressed sentiments which suggested they feared they might still be seen in that way. For example, Tom, who had not had surgery yet and was not sure he deserved it despite years of failed dieting, said:

1385 T: so y'know I don't deserve to be successful and slim and happy
…
1391 what's the point of tryna' eat sensibly you know
1392 you're a lazy fat idiot

Margaret, who was down to a size twelve, said she did not like to ask her GP about the side-effects of WLS – in her case these were hair loss, feeling the cold and dry loose skin - because she had already cost the NHS a lot of money:

934 M: so I guess I feel a bit guilty
935 silly isn't it
936 I don't feel guilty about going to see him about something else
…
939 nah this is not really a real illness to them
940 that's why they think
941 I should be thankful for what I've got

Hannah also suggested that she should be able to do it herself:

1314 H: it was like I was cheating really um

1315 I felt like I was cheating

1316 um having the surgery

George did not tell people at work about his WLS because he did not want to be judged for taking "the easy way out" and not doing it through self-discipline and willpower, virtues commonly presumed to be lacking in fat people:

966 G: I didn't want them to judge me

967 and to imagine

968 that I've taken the easy way out (J: ok)

969 uh

970 J: it's not easy

971 G: i-it's not an e-easy way out

972 but I didn't want it to be considered as a weakness

973 o-or an easy option

…

993 *G: and I don't want to be judged*

994 *tse I don't want to be judged*

5:2:3 *Shame and embarrassment*

Six interviewees talked about the shame they had felt in the past when, for example, they had to ask for an extension to an airplane seatbelt and of their pleasure now in not having to do so. Margaret would get her husband to do her seatbelt up while she held her breath – just so that she would not have to ask for an extension. On one occasion she had to have two seats on a plane and heard the disparaging remarks other passengers made about her taking more than her share of space. Hannah described her humiliation at a fun fair when she had been too big to fit on the rides.

Anne had her surgery four months before we met and had lost a considerable amount of weight, but her experience of her body had not caught up with the loss and she feared that others would see her as she saw herself:

891 A: I'd always done aqua-aerobics

892 and it was as I got bigger and bigger and bigger

893 I stopped goin'

894 because I was embarrassed about my size

…

907 I should get

908 get into the gym (J: yeah)

909 but there's still that thing

910 at the back of my head y'know

911 people are gonna laugh at me (J: yeah yeah)

912 and I think I need to lose a bit more

913 before I join the gym again (J: yeah)

914 I'm still in my mind

915 I'm still too big (J: yeah)

916 I don't want people sort of starin' at me

917 and laughing

Margaret talked of situations which previously had been potentially humiliating and had required some strategy to avoid discomfort:

978 J: d-do you actually find

979 that you still experience yourself as quite a bit bigger

980 M: (.) nn I think

981 I think pr-

982 I did at the beginning

983 I'm getting used to it now

…

989 but I'm getting now

999 that I'm not worried about where I sit in a restaurant

1000 whereas before I always used to look for a place

1001 where I could get out easily

1002 I wouldn't have to try and move people

1003 and all that sort of thing and uh (J: yeah)

1004 if you did have to get between people

1005 it was very embarrassing

1006 but now if I have to squeeze between two people

1007 I'm not worried

1008 because I don't feel that I'm huh huh that gross a person

1009 or that big a person

5:2:4 *Invisibility*

Claudia described the anomalous experience of many big people where they are physically more visible, there is literally more of them to see, yet they are othered, treated as non-members, outsiders, and therefore not 'seen'.

359 C: 'cos another classic is when I used to do the school run with the children

360 when I was nearly twenty-seven stone (171kgs) (J: yeah mm)

361 I was invisible

362 (missing – none of the) mothers wanted to talk to me or anything (J: mm)

363 they had their little cliques (J: mm)

364 since I lost the twelve stone (76kgs) (.)

365 they come up and talk to me

366 and chat to me and everything

367 and I thought ok

368 so when I was hu-uge I was invisible (J: yeah)

369 and now that I've shrunk

370 I'm suddenly visible (J: mm)

5:2:5 *Sex – or the lack of it*

There was a relative absence of talk about sex and sexual attractiveness or it's loss. Three participants mentioned it – and then only in passing. This may have been because the majority were over fifty and in stable relationships, or possibly because talking about sex to an older person like myself may have felt uncomfortable or inappropriate. Certainly, prior to surgery they would have been too large for sexual intercourse to be possible, and subsequently there would be the problem of substantial amounts of loose skin which would make the individual feel unattractive, and would interfere with achieving intercourse. As I tried not to guide the conversation, but chose instead to follow where it led, this lack of sexual talk seems relevant. It is indicative of the contradictory position in which large people find themselves - they are depicted as being too sensual and greedy, therefore sexually dis-inhibited, but also as having hidden their attractiveness under layers of fat thus presenting themselves as asexual.

For example, George said that the partners of his women friends were not worried about their friendship with him - as though he were a eunuch:

1200 G: you're not seen as a threat when you're fat

Tom, who was awaiting surgery said:

635 T: ... women's response to me (J: mm hm)
634 um (..) and I think
635 almost being this overweight
636 it's almost as though you you lose your (.) masculinity (J: mm)
637 th- women don't tend to respond to me kind of as a man
638 so I have collegial relationships with women
639 and actually I think a lot of the kind of male female dynamic
640 just isn't (.) really there in that way

5:2:6 *It's all a cover up*

Another aspect of the stereotype is the jolly fat person. My participants made it clear that this was a disguise and a form of self-protection used to keep others at a distance. I asked Thelma:

1269 J: some people have said to me
1270 that they actually mind being smaller
1271 because they've got so used to being big presences
1272 that they actually feel that they've lost something
1273 when they've got smaller
1274 Th: one thing I have found
…
1279 I've not had that support through being big (J: right)
1280 yes I've had the bravado (J: right)
1281 ok I'm big I've got the (indistinct)
1282 so you get loud
1283 everyone thinks you're confident (J: right)
1284 you're happy all the time (..)
1285 but you're not
1286 it's all a cover-up (J: yeah yeah)
1287 you will find a lot of obese people are brilliant liars (J: oh yeah)
1288 because they've had to learn that
1289 to cope with being big

Monica, (Chapter4:5) struggling with the change in her self-perception due to her rapidly decreasing size, very much wanted to talk with others who were having difficulties too, but support group members were unresponsive:

2403 M: and a lot of the big people
2404 especially at the (support group) meetin's
2405 they're jolly
2406 and they're bubbly
2407 and they're chat chat chat
2408 go 'n have a cup of tea y'know

2409 and I ate this last night 'n (.)

2410 which is what we do

2411 and it's all a big front (.)

2412 they they don't think we see it

2413 but obviously bein' a big person myself

2414 I know it it is a huge front

5:2:7 *Who is willing to use the tool of WLS?*

It was in talk about others that the loathing of fat was most evident - as was the placing of sole responsibility for their state upon the big people themselves. This showed most when I asked if interviewees had thoughts about who was most likely to benefit from WLS. I began to ask the question because it was a subject that came up in all the earliest interviews. It interested me because, as I said in Chapter Two, discovering who would benefit from WLS appears to be a 'holy grail' of much research.

Group leaders in particular placed great emphasis on the surgery being a 'tool' that the individual has to use appropriately – with an implied reference to the old saw, 'It's a bad workman who blames his tools'. So the question, 'Is it the appropriate tool?' is not asked, the assumption is that the tool does not fail, it is the individual who does not use it properly, thus locating the blame for any weight-regain squarely upon the person. Neither the medical profession nor the group leader bears any responsibility because they have provided the best tool and all the information and support necessary to make good use of it.

Tracey (Chapter4:4) - an enthusiastic and energetic leader who was down to a size twelve/fourteen and a keen advocate for WLS - in describing people who either did not lose weight at all, or who regained it, said:

685 T: erm the band hasn't failed you

686 but you may have failed your band (J: yeah)

...

956 you come out of denial about yourself you know

957 and it's no good turning round

958 as a thirty stone (190.5kgs) man once did

959 and told me he eats nothing but fruit and veg

...

964 nothing no surgery can pull your head out of the ground

...

966 the best lesson you can learn

967 is that they have to take responsibility for themsel'

968 the NHS are not gonna cure their problems

969 or the Bariatric Group

970 or anybody else

971 people will still continue to (fail?)

972 (until) they take responsibility (.h)

973 because they are responsible (.)

974 I asked a-a gentleman that hadn't done well one day

975 and I said to him

976 who was responsible for what you put in your mouth (J: mm)

977 and he thought for a moment

978 and he said well I suppose I am

979 and I said exactly

980 you are responsible for yourself (J: mm)

981 for the way that you look

982 and for what you do

983 and for-for all the rest of it

984 it's yourself (J: mm)

985 (sniff) and that is that is the key (J: mm)

Her use of direct reported speech adds emphasis to the blaming discourse of which she makes use. The language Tracey uses has a flavour of Christian revivalist meetings (Stinson2001;Johnson2018;Wolf1991) - the path to virtue and to heaven (slimness) is straight and narrow but stony ground is the resting place for much of the poor farmer's/group leader's scattered seed.

898 T: I get frustrated sometimes (J: right)

899 sometimes if I'm with people who I want to motivate

900 I try and take them back

901 back to basics

902 in order that they will succeed

903 and sometimes people won't listen (J: right)

904 because I know

905 that if they follow a very simple formula

906 I know that they will succeed

907 and if they are determined enough

908 they will succeed

In the following example Claudia, another group leader, also uses direct reported speech to illustrate her point. This was something most of my interviewees did when talking in a negative way about others. It was as though the apparently verbatim quotes gave the report a veracity and impact it would not have otherwise. This form also distances the speaker from the action and players being described, thus distinguishing and absolving themselves from such behaviour.

467 C: when people say

468 oh yes I can cope

469 I can do this

470 and I thought no you can't

471 because you've lied to yourself

472 and kidded yourself

473 all these years

474 that it's not your fault

475 you've put on weight

476 it's not your fault that

477 you're putting all the food in your mouth

478 so if you can kid yourself about that

479 you can kid yourself sometimes

...

1040 C: some are lazy

1041 I will say it

1042 some are lazy

1043 they think the op'll do it for them

1044 they haven't got to do any work

1045 they lose the weight

1046 and then when the weight creep back on (J: mm)

Kevin, another group leader, also used the spoken form when describing a scene to illustrate the 'wrong' attitude to having WLS:

629 K: I had somebody .h who was in hospital

630 and they wanted me to go and visit them

631 her brother came in

632 her brother had a band back in about two thousand and three

633 he was a failed(?) band patient in S (J: right)

634 and he came in to see her

635 and he said

636 oh here's the stuff you asked for

637 (indistinct - and he handed her) a bag

638 and it was all crisps

639 and she starts eating crisps

640 and she's still in hospital just after surgery (.) .h

641 I said you can't do that

642 oh I want them (.)

643 I walked out (.)

644 wasted (.)

Seven interviewees used the phrase "fat head" which seemed to have a variety of meanings within the support groups. The essence appeared to be that WLS does not cause the loss of the desire to overeat, and it is only the physical restriction

or side-effects, coupled with firm self-discipline, that enables a person to maintain their weight-loss. There did not appear to be any suggestion of irony in the use of the phrase and its connotations of stupidity remained.

5:3 Food

When I embarked on this project, I anticipated that an emotional response to the inability to consume food and drink in ways that had been possible in pre-WLS times would be a big part of the talk of my interviewees. With the notable exceptions of Monica and Claudia this was not the case. Claudia described the shocked reactions of some of her group members to no longer being able to eat freely:

483 C: afterwards it's a shock
484 when they realise (.h)
485 oh my god I can't do this
486 I can't do that
...
492 it's fine this is normal (.h)
493 and I think that's half the thing
494 it's actually
495 it's quite a normal process to me as well
496 it was like a grieving process I was going through
497 it's like I was losing a part of my life
498 I was losing a friend in a way
499 because I think I always looked at it
500 that comfort eating
501 that I was getting a hug from my friend
502 my friend will make me feel better
503 (.) so-o yeah (.)

5:3:1 *Concrete talk*

I am not suggesting that there was little or no talk about food: far from it, there was a great deal about how people were eating now. "Fat head" was used frequently and there was nothing that could be done to change it except to "follow the rules" or go "back to basics". These aphorisms function as strong and pithy statements of truths that are beyond question. They are rhetorical devices which make argument or challenge appear redundant. The suggestion is that the answer is simple – Johnson calls it the "simplicity discourse". (2018p149)

I was given plenty of concrete detail about the recommended post-WLS diet. This is Margaret talking about what she would do if she started to put weight back on:

636 M: I would just go through the whole diet
637 back to basics
638 and just cut out everything I shouldn't be eating
639 and up the protein and vegetables and fruit and stuff
640 I do eat more fruit now than I used to (J: right)
641 one thing I'm not so good at is vegetables
642 I do eat vegetables
643 but maybe not so much as they would want to
644 and the other thing I know I'm bad at
645 and (the nurse) keeps telling me
646 um I eat too quickly
647 I don't wait
648 I I don't count me chews
649 and I don't wait for a full minute
650 I did I
651 I had to in the beginning
652 I think you've got to in the beginning
653 because it's so difficult to go down
654 and I know that's a fault
655 he wants me to think about it
656 and I did think about it

657 .huh chewing and chewing away huh

658 and then I get distracted or

659 and I'm just back to eating as I normally would (J: right)

660 and so I know that there are some things

661 so if I started to put weight on

662 I suppose that's something

663 that I could work on better than I

664 I do try I do try (J: right)

665 but I find it so hard (J: right)

666 I mean in the beginning

667 you get used to the cold food at the end of the fifty minutes

668 and you can't

669 they said chew twenty times

670 wait a minute

671 and stop eating after twenty minutes

672 well you haven't got time have you

673 how can you eat your food

674 and stick to those rules

675 it's impossible

Margaret demonstrates that she knows the wider discourse of healthy eating and suggests some acquiescence to it by telling me that she is not eating enough vegetables. Would she have talked like this to a friend, or might there have been more scepticism about, or resistance to, the dominant discourse? In our conversation she was presenting herself as someone who is prepared to work at making a success of the surgery, but in her case she was not suggesting that there was a 'new me'. (Groven et al2012;Longhurst2005;Murray2009;Throsby 2008;Young&Burrows2013). The original Margaret was still there doing the same things and would have to be brought into line if she started to gain weight.

All the people I spoke to demonstrated that they knew the rules laid down for post-surgery eating, but in Margaret's talk she is more openly rebelling against them than some by suggesting that they are nonsensical, they do not conform to

normal eating. As Throsby (2012b) found, these small rebellions tended to be directed towards dieticians, or in this case a nurse, and not to the surgeons. Frustration with staff lower down the medical hierarchy was expressed by seven of the participants although it tended to be coupled with praise as well. These could be viewed as "subversive practices" in reaction to dominant health discourses as Willig (2000p554) suggests and as Fat Activism would argue.

The concrete nature of the rules was similar to those of many widely available diets. Given that these had failed to enable the interviewees maintain weight lost in the past, one cannot help wondering how they can be expected to work in the future – yet joining a slimming organisation is regularly recommended to WLS patients. This is evidence of the power of the dominant discourse about the causes of and cure for obesity, i.e. it is a simple matter of willpower and if only fat people would properly monitor their intake of food and drink then everything would be alright. In her talk about good and bad foods, and of behaving with restraint in what and how she eats, Margaret ([639-642]p151) shows her familiarity with a moralistic dieting discourse and the cultural narrative of the virtues of self-control and denial which is deeply rooted in Christian teaching. (Wolf1991)

She and Hannah talked of eating crisps or sweets and chocolates in the evenings in their unhappy first marriages, and George said he ate in the evening too as a reward for surviving a stressful day at work, but none of them expanded this beyond the bare statements of what they had done – this despite my having asked what food meant to them. What did this omission achieve? It functioned as a full stop for me, a 'go no further' sign, there is nothing more to be said. It was the only point at which any of my interviewees showed distress, in that tears welled up in Hannah's eyes as she spoke.

As I said in the Literature Review, it was noticeable that Meana & Ricciardi (2008) deliberately chose not to include food in their book about the experience of WLS. Radcliffe (2013) only writes about how to manage the changed way of eating and, although her book is interspersed with quotes from her patients, the

only ones that reflect an emotional response to the loss of an old way of eating are taken from other authors - which suggests to me that she similarly heard little about the meaning of food or about any experience of loss.

5:3:2 *The lack of symbolic talk about food*

Gee (1999) distinguishes between the speech of different social groupings and demonstrates that applying the linguistic conventions of one group – in my case psychotherapeutically-informed, academic, middle-class speech to the talk of mostly working-class people – can lead to misunderstanding, misjudgement and a potential under-estimation of the complexity that is there. If I am not to view the little that was said about the loss of food as an 'impoverished' discourse (Emerson&Frosh2009), then my attempts to look for what underlies it should be a recognition of richness of meaning. Emerson and Frosh describe this as a "…commitment to meaningful interpretations of marginalised or subjugated sense-making…" (ibid.p62). When I asked people about what they might replace eating with after WLS, I think I was looking for an internal accounting of and for themselves that was not a normal part of their interactional repertoire. To seek a more complex account of a relationship to food and eating runs counter to the dominant discourse of individual responsibility for health which privileges simple equations like 'energy absorbed should equal energy expended' and presents maintaining a 'healthy' weight as an equally simple matter of moral strength and willpower. In this context, offering a psychological explanation of acts of overeating is to make unwarranted and irrelevant excuses.

An example of this occurred in my interview with Anne. She told me of a recent occasion in which she had experienced dumping because she had not stuck to WLS rules. I asked her to tell me the circumstances in which it had occurred and she gave an account of being angry with a work colleague whom she described as getting away with laziness. On her way to work after a particularly annoying event Anne had bought a pudding and eaten it:

476 A: I don't know why but (indistinct)

477 I fancied something sweet (J: yeah)

478 and I picked up

479 er a Count on Us dessert (J: right)

480 and I didn't check the sugar content (J: right)

481 (.) and I knew it (h.)

482 because these days

483 I tend to sort of check that on everything

484 and why I didn't check I don't know

485 I suppose I just picked it up thinking

486 oh well that's a one of the healthy options

487 didn't check it

488 and it was high in sugar

489 so yeah it might have been low in fat

490 but it was high in sugar

....

519 J: do you think there was any reason why you didn't check

520 I mean were you feeling tired or stressed or (.) t-eed off or

521 A: yes I was (J: right)

522 I was really annoyed with one of my colleagues (J: right)

I asked what she made of the connection between eating the pudding which led to her suffering an episode of dumping and her anger and whether she saw it as 'emotional eating' - a phrase commonly used in weight management services. Her reply was:

540 A: yes it's a gave me a kick up the backside

541 to make sure I double-check everything (J: right)

She then went into a detailed list of the sweet things she could eat if she felt the need in similar circumstances because she was "never gonna lose that fat-head ever". In other words, there was no room for further discussion with me about it. She did not offer a personal narrative about the desire to eat, only a medical one which is evident in the simple expedient of reducing someone's capacity to

eat by making the stomach smaller. It is also there in the considerable research which is going into finding an endocrinological solution to the experience of hunger. (Chandarana&Batterham2011;Larder&O'Rahilly2012;Scott&Batterham 2011). In the above Anne constructs an identity of herself as someone with a no-nonsense approach to her life-long problem of having a "fat head" – she will just be firm with herself and stick to the rules with any back-sliding severely punished. There is an appeal in the straightforward message of the support group, i.e. that there is no getting rid of the "fat head", just keep it under control. This conforms to the dominant message that the problem is a simple one, and side-steps the accusation of moral failure by accounting for over-weight as being the result of an 'addiction' to food.

5:4 Conclusion

Perhaps the most striking feature of WLS is that it is an admission of an inability to control one's actions, in this case the quantity of food eaten, and the search for an 'external' brake in the form of an alteration to the stomach which physically restricts the amount of food that can be ingested and removes or reduces the sensation of hunger. With regard to being accountable for their weight, my interviewees conveyed a lack of a sense of their own agency while simultaneously voicing the neo-liberal discourse of personal responsibility for their size and their health. They moved between these positions in the chronology of their accounts by attributing their past overweight and way of eating to factors beyond their control, yet saying that in the future they would blame themselves if they regained weight because they would have failed to follow the WLS 'rules'. There appeared to be no question of blaming the surgery as being inadequate or inappropriate for the task.

In this chapter I have looked at those aspects of my interviewees' talk which related to the dominant discourses that account for 'the obesity crisis' and the 'solutions' to it, such as the simple exercise of restraint in consumption of food and drink, and if that is not done then the restraint must be achieved by surgery.

I noted the fattism inherent in this argument and its presence in the participants' talk. Finally I looked at the concrete nature of talk about food.

Chapter Six: Discussion

The aim of this research was to hear the experiences of people who had undergone, or were about to undergo WLS, and to relate these to the prevailing discourses around body size and health and the use of surgery as part of the 'solution' to the 'obesity crisis'. My reason for choosing to explore individual accounts was their relative absence in the literature specifically related to the treatment of obesity which I discussed in Chapter Two. The literature review, the results of a preparatory focus group, and my clinical work, also raised questions about the relationship with food after WLS.

My questions to the participants were:

- 'I would like to know about your experience of WLS?'
- 'What has happened to how you feel about food now that you cannot eat in the way you used to be able to do?'.

In this chapter I concentrate on talk which seemed most pertinent to the dominant discourses around a 'simple obesity' and its causes and cures. I explore how people accounted for their weight; where responsibility for it was described as lying; how temporal shifts in the participants' accounts dealt with 'trouble' in attributions of responsibility; the role played by discourses of transformation and rebirth; the mis-match between patient-perception and the medically-defined problem; fattist positioning and othering in the talk; the concrete nature of the approach to food; and the long-term. I describe some limitations of my study; consider what I have added to the field; look at implications for clinical practice; and finally at a possible area of future research.

6:1 Methodology

In Chapter 3:3:6 I argued that, as I have chosen to accept Wittgenstein's (1953) claim that we cannot *know* another's internal states from their talk, it would be a

contradiction to use psychoanalytic theory and clinical method to interpret my data within a discourse analysis. Avdi and Georgaca (2007a) term the basic differences between the two systems an "epistemological incompatibility", although they do suggest that the resulting tension can be a useful goad to critical reflection about one's clinical work.

I chose to use a synthetic approach to DA because it gave the tools with which to explore the answers to my questions in detail, and a way of hearing the individual voices of participants while also critically illustrating the wider discourses evident in their talk. It is a means of making things 'strange' or challenging taken-for-granted assumptions. I was attempting to stand outside all that is familiar, without alienating myself from the subject at hand – being both a member and a stranger.

6:2 Results

6:2:1 *The Neo-liberal Subject*

Using existing DA research I have discussed the increasingly neo-liberal approach to health-care in which responsibility for health is individualised, patients are 'empowered' to take this responsibility (Knutsen,et al2013), and structural inequalities associated with ill-health are accounted for in terms of bad life-style choices made. (Boero2013;Johnson2018;Monaghan2005;Radley& Billig1996). This is a 'simple' obesity (Aphramor2010;Dulloo2012,2013;Johnson 2018;Throsby2007,2012a) in which it is presented as an obvious fact that excess weight leads to ill-health and slenderness equals health (Cairns&Johnston2015), and the body is viewed as "a modifiable personal characteristic" (Donaghue& Clemitshaw2012p416). If the bulk is removed and prevented from returning, then that person will automatically be healthier. The excess weight is explained as being simply the result of improper diet and inadequate exercise, which can be treated by the straightforward solution of restricting, by surgery, a person's capacity to take in food and by exhorting them to exercise. This simple equation

of health and slimness has been challenged by Fat Activism and the Health At Every Size movement. (Bacon&Aphramor2011).

In this climate, discourse analysts have pointed out that being overweight becomes a moral problem and large people have to account for their size in ways which limit accusations of irresponsibility. (Drew2011;Knutsen&Foss2011; McDonald,et al2007;Scholz2009;Spitzack1987;Stinson2001;Throsby2009;Webb 2009). My interviewees demonstrated sensitivity to this by accounting for their past weight in similar terms to those found by other DA researchers. A distinction was made between the ‘past me’ and the ‘new me’. There was a time-shift in identity – helpless but hard-working in the past, responsible (and hard-working) in the future. They spoke of themselves in the past as having been victims of food addiction, genetic heritage, or circumstances beyond their control such as upbringing and family culture, but in the future they would be transformed by WLS. They would become someone able to control their intake. (Maor2013;Throsby2008;Wood&Ogden2016). But many said that it was only because of the *physical* restriction provided by WLS that this control was possible – they did not consistently suggest that they had undergone a character change.

There was a complication in that they constructed their past identities as passive responding to circumstances, continuing to put on weight despite making considerable efforts to lose it. This helplessness circumvented the accusation of not taking proper care of their health, while the effort built an identity of someone who was not afraid of ‘working’ (Stinson2001) to lose weight and would therefore, in the future, be a suitable and worthy candidate to use the ‘tool’ of WLS. Awareness of the narrative that big people do not take care of their health, and make irresponsible use of scarce NHS resources, was demonstrated when they talked of feeling guilty for having had surgery and of not liking to ask for extra help with side-effects. (Margaret,5:2:2[934-941]p140-141). This kind of talk is reported in most of the DA literature on WLS. (Knutsen&Foss2011a; Knutsen et al2011b;Knutsen et al2013;Wilson et al2007).

The participants in my study showed compliance with the discourse of individual responsibility for health after WLS. There was an acceptance of the requirement for self-surveillance and policing of their bodies. Not only were they members of a support group, they also talked of attending the "educationals" – ie. information sessions offered by the hospital - and showed that they had absorbed the information given about healthy eating within the constraints of the post-surgery diet. They made cautious predictions about how much weight they expected to lose – while reporting that staff had suggested greater losses – thereby suggesting that they were reasonable and realistic and not hoping for miracles. All said that they were monitoring their weight and would 'go back to the basics' of diet and exercise should they begin to regain. This drawing on medical discourses and active control of lifestyle "…represent(s) a normative rather than a radical and empowering process. (Knutsen,et al2013p67)

Obesity is viewed by some as a chronic disease. (Rippe,et al 1998). The failure of common treatments for the condition confirm its intractability, and my interviewees bore witness to having tried repeatedly to lose weight, only to regain what was lost and more. (Sjöström2013;Dulloo2012;Dulloo,et al2012;Garner& Wooley1991). That WLS is viewed as a last resort was evident both in the literature and their conversation - it resulted in a lot of hopeful talk. (Grave,et al 2005;Groven,et al2015;Wysoker2005).

The physical toll taken by morbid obesity is considerable and I expected participants to account for their choice of WLS on medical grounds – but that was not the case. Talk of health benefits – central to medical obesity discourses - was absent, instead interviewees talked almost entirely about weight-loss. The medical reasons for performing WLS relate to the need to reduce the incidence of Type II diabetes; sleep apnoea; high blood pressure; a number of cancers; joint problems; etc, but none of my participants mentioned these, other than joint problems, as being the reason for having surgery. Ryden and Torgerson (2006) suggest that perhaps the connections between some of these conditions and weight are not sufficiently clear or concrete to make action against them feel necessary or possible. The chance of getting some form of cancer in the future,

or knowing that one has high blood pressure which may have no obvious symptoms, can seem too nebulous to be related to one's size. The participants did not talk of obesity as a potential killer. There was a mis-match between, on the one hand, the medically-defined 'problem' and, on the other, the patient-perceived one (Diaz Martinez et al2015) which, if not attended to, must reduce the effectiveness of any treatment. This relates also to the differences between doctor's and patient's views of the causes of obesity and of what would constitute successful weight-loss as a result of surgery. Coulman et al (2016) also found that medical professionals tended to judge the success of WLS in terms of the amount of weight lost, whereas patients placed more importance upon all the effects of the operation – physical, social and psychological. The amounts lost were significant in the talk of my interviewees, but the struggle with side-effects was also notable.

6:2:2 *Fattism and Othering*

The anti-obesity discourse prevalent in this culture was present in the participants talk – both as victims of the humiliations of being large, and in their disparagement of other big people. This internalisation of societal disgust at fat was most evident when opinions were expressed about who would or would not make use of the 'tool' of WLS. Accusations of laziness were levelled at those who were apparently not successfully losing or maintaining weight-loss, thereby giving voice to the stereotypical version of the lazy fat person, part of the "collective knowingness" about big people, while having established themselves as willing and able to put in the necessary work to succeed. They had built a compliant identity, accepting responsibility for using WLS appropriately and seeing their future body-size as a "modifiable personal characteristic" (Donaghue &Clemitshaw2012p416) which was within their control.

There was talk of 'what big people are like' which was used in an othering manner by drawing a distinction between themselves, as hardworking users of WLS, and those who did not or could not use it successfully. Not only were those who were failing dismissed as not trying to help themselves, there were also

descriptions of a ‘cover up’ in their behaviour. There was talk of “bravado” (Thelma); of hiding behind busyness that achieved nothing (Tracey); and of a refusal to discuss the difficulties of life after WLS (Monica). These were members’ accounts of defensiveness on the part of an (O)ther There were also positive examples of a ‘brave face’ being shown such as that of Nichola (Chapter4:2) in her use of laughter in ‘troubles talk’.

6:2:3 *Food and Hunger*

Previously I noted that there was remarkably little discussion in the literature about any changes in the relationship to food after WLS. Food and eating tended to be dealt with in concrete, practical terms with descriptions of the commonly reported changes in taste and texture that by-pass methods of WLS can produce, plus detailed accounts of the post-surgery diet. There was (to me) surprisingly little about what it might mean to a very large person to be limited in what and how much they could eat. Wood and Ogden’s (2016) IPA paper is one of very few to ask the question, “How has your relationship with food changed following your surgery?” (p2449). They found a wide variation in changes after surgery from a reduction in the importance of food to an “…importance exhibiting itself as an obsession.” (p2451).

Given that I write from within a psychoanalytic discourse which suggests that overeating has meaning for the individual as suggested by Magdeleno et al (2010), I expected the interviewees to talk about what food meant to them, to demonstrate an understanding of how they had used food prior to surgery, and to express feelings of loss and fear at not being able to continue eating in the way they had done previously. These were largely absent. Such silences were not only in the interviewees’ talk, but also in the writing of other researchers. Following Billig’s (1999) method of noting absences in text and talk, I question what this absence might signify. I argue that it conforms to the dominant discourse of a ‘simple’ obesity in which the answer to the question about how big people relate to food is already given – it is regarded as a matter of irresponsible greed or ignorance, as a result of which too much is eaten and too little energy is

expended. Hunger is treated as a purely physiological phenomenon, a 'simple' hunger, to be responded to appropriately, whereas Ogden and Wood's (2016) participants, like Hannah (Chapter4:3), gave a more complex picture.

The interviewees had built a pre-surgery identity as someone who was at the mercy of external forces such as heredity, family custom, or addiction to food, which, despite their strenuous efforts to lose weight, made it impossible for them to maintain weight-loss. There was no talk of having eaten too much in the past - which would lay them open to accusations of having been irresponsible with regard to their health. But this "telling" (Taylor&Littleton2006) would make it difficult to talk now about missing being able to eat as had previously been the case, because that would suggest that pre-surgery ways of eating had been excessive - something that had been avoided. The new, post-surgery identity was one of careful monitoring of intake, both in terms of quantity and quality. All gave evidence of adhering to the 'healthy eating' discourse in the sense of knowing what they should and should not eat, and were clear that if they began to regain weight they would immediately return to the basics of a healthy diet. Implicit in this is the belief that a 'healthy diet' results in weight-loss which equals health.

6:2:4 *The Long-Term*

Regaining some weight after the initial period of rapid loss is quite usual but the participants talked in conflicting ways about it. On the one hand there was talk of 'going back to basics' (Margaret,5:1:7[637]p151) as the simple way of dealing with it, but on the other there was fear or even disbelief that it could happen. Given that WLS is regarded by many as a last resort and carries with it talk of being a 'new me', transformed or reborn, then to regain some weight could be problematic. In this context, most of the authors of qualitative research papers recommend that there should be long-term support after WLS. Jackson et al (2017) said that their interviewees felt as though the support 'dropped off a cliff' after surgery and Ogden et al's (2011p961) participants "...also described how they felt that although surgery addressed their body it neglected their mind

which concurs with recent NICE guidelines calling for psychological support pre and post WLS (NICE, 2009)." If obesity is a chronic disease as some would have it - or the response of a stone-age body to a time of plenty – either way, the cure cannot be a short-term one.

6:3 Limitations

(i) The most significant limitation of this study was the lack of people for whom surgery had not worked – a situation that is not uncommon in all forms of health research (Goldacre2012). As already mentioned, the 'failures' leave discussion forums, do not attend support groups, and are less likely to maintain contact with their medical teams. I heard of such people, but was unable to make contact with any. There is of course the possibility that some of the stories I was told were in the nature of urban myths or cautionary tales, but I do not believe that all were. In a context in which responsibility for their condition is placed solely upon the fat individual, then retreat would be the most likely response to failing to maintain weight-loss. (Young&Burrows2013).

(ii) Because of the enormous excitement, upheaval, and need for adjustment produced by initial rapid weight-loss, I should have had a greater proportion of people who were not in the first two years post-surgery. Unfortunately they are more difficult to contact because they tend to leave support groups unless they are keen promoters of WLS. The result was that most of the people I spoke with were advocates for WLS.

(iii) The relatively small size (twenty) of my sample would preclude generalisation from my results but, as Coulman et al suggest in their paper synthesizing qualitative small-scale studies on the experience of WLS, "(q)ualitative synthesis offers a way of bringing together disparate studies and overcoming issues of sample size and focus, generating clinically useful knowledge." (2017p548).

6:4 What have I added?

My findings were in line with those of other DA researchers. In some areas, such as talk of being transformed into a "disciplined subject", the responses of my interviewees were more nuanced, contingent, and complex than suggested by many. Also, there was more overt adherence to an anti-fat discourse among my participants than often reported. Many authors did not place as much emphasis on the role of structural inequalities as I consider necessary to understand why there is a preponderance of overweight in socially disadvantaged groups. It is important to acknowledge that this medical treatment is offered as a simple, and pragmatic, solution to an obesity which mostly arises in conditions of disadvantage. It is also relevant to question why more women receive surgery, even though rates of overweight are equally distributed between the sexes – this cannot be a choice made on medical grounds alone.

My most significant findings were the participants' shifting in their talk between passive and active over time as a way of dealing with trouble in accounting for their pre- and post-surgery identities. The passivity in the accounts of their pre-WLS selves meant that they required rescue from an external source because they had demonstrated helplessness to effect change despite endless efforts at losing weight. But, in order to show they were capable of using the 'tool' of WLS, they had recourse to this evidence of a capacity for effort to build up an identity of an individual who is not afraid of putting in the necessary work. I suggest also that giving 'right answers' such as their familiarity with healthy eating guidelines; getting "back to basics" if they strayed from the dietary recommend-ations; not having a target weight; even their apparent unawareness of normal weight regain; and the hope that WLS would produce a change in them, such that they would be able to maintain the weight-loss in the future; all positioned them as worthy and compliant subjects of WLS.

6:5 Implications for Clinical Practice

6:5:1 *General Implications*

Continuing, long-term support for people who have undergone WLS is recommended in most of the qualitative literature. Groven et al (2012,2013) highlighted the difficulties of living with dumping, significant bodily change and excess skin. Natvik et al (2013,2014) described continuing problems with eating and fear of weight regain. Simpson argued that the achievement of 'health through thinness' was at the cost of "…increased self-surveillance, regulation and control in order to maintain their health through thinness." (2015p1). Jackson et al (2017) found that five years post-surgery, changed eating habits were still not habitual. Jumbe and Meyrick (2018) concluded that long-term support was needed to help people cope with the major changes that WLS produces. Engström and Forsberg (2011) found that when the physical restriction provided by WLS began to diminish, then patients needed help to cope with this. Knutsen et al's (2011;2011b;2013) participants talked of feeling as though they had been abandoned post-surgery when compared with their pre-surgery preparation. From their systematic review of qualitative studies into WLS, Coulman et al suggest that their "…findings demonstrate the importance of long-term support, particularly psychological and dietary…" (2017p547) to help people negotiate the changes produced by WLS – particularly the difficult experience of weight regain.

As I discussed in the Literature Review, in a context in which it is a 'simple' obesity that is being treated by WLS, where weight is considered to be a matter of choice, then post-surgery support would seem to be superfluous. Such support only makes sense if obesity is viewed as complex and multi-factored, which the qualitative literature suggests it is.

6:5:2 *Specific Implications for Psychotherapy*

In the following I will outline some specific implications of my analysis for psychotherapeutic practitioners.

Georgaca and Avdi (Avdi&Georgaca2007a;Georgaca2001,2003,2014;Georgaca& Avdi2012) advocate the use of DA by mental health professionals as a means of

developing reflexivity by challenging taken-for-granted assumptions. "It is our view that, to a certain extent, the tension between deconstructive research approaches to therapy and clinical practice is inevitable, partly because of the epistemological incompatibility between constructionist perspectives and most approaches to clinical work and partly because of the different aims of research and clinical practice. This tension, however, can be a source of critical reflection on one's therapeutic practices and values. Moreover, we contend that, if critical discourse analytic studies shift their focus from macro-processes to the interface between subjectivity, interaction and wider social processes, this would render them more useful to clinicians, while still retaining their critical edge." (Avdi& Georgaca2007a,p173)

The rigour of the methods of recording, transcription, and analysis used by discourse analysts could be of value to practising therapists. Although recording therapy sessions is contrary to usual psychoanalytic practice - even in training - on the grounds that it would be a disruption of the analytic frame, I suggest that a lot can be learnt from doing it. This is contrary to most psychoanalytic thinking which privileges the analyst's memory of a session. I am not suggesting that transcription and analysis are a 'truth' about what happened, but they could be a useful means of noticing what was forgotten which gives one the opportunity to reflect on possible reasons for the forgetting. Billig argues that "(b)ecause what is left unsaid can be as ideologically important as what is said, there is a need to investigate socially reproduced unconsciousness." (2006a,p17). I regard blanks in the analyst's memory to be as interesting as gaps in the patient's story.

DA highlights the need to understand the role of prevailing discourses in shaping our attitudes towards the big people who approach us for therapy. I have argued that the medicalised discourses around the causes of and cures for obesity are so powerful that to resist them is seen as a denial of reality. As clinicians we should be aware of our personal reactions to fat, whether on ourselves or our patients and be prepared to explore them in the consulting-room. (Sherman-Meyer2015; Tintner2007). Ingram (1976) warned of the risk of entering into a "regrettable collusion" with the large person where both despise the fatness, and it is

important to be able to distinguish between participation in current discourses and our counter-transference. (Drell1988;Farrell2004)

My conversations with the participants confirmed the great difficulty of maintaining weight-loss – they all reported regularly losing large amounts only to put it all back on again as soon as they abandoned their chosen method – and the real intractability of overweight needs to be taken into account. It is unhelpful, even omnipotent, to enter into a therapeutic contract with the aim of helping a person lose weight. The resulting frustration with our inability to effect change may lead us to put the blame onto the individual rather than allowing ourselves to experience our own feelings of helplessness and ineffect-iveness.

6:6 Possible future research

In the light of the limitations discussed above, (6:3), and with the caveat that if I had the funding and the time, I would seek out some 'failures' to hear their accounts of their experiences. Their voices need to be added as a counter-balance to those advocating WLS as one answer to the 'obesity crisis'.

6:7 Conclusion

In line with other DA researchers, I have noted the moral panic over obesity and the neo-liberal emphasis on personal responsibility for health. The equation of health with weight-loss has been critically analysed and I have said that a 'simple' obesity has been constructed which legitimates WLS as a solution. The pressure for individuals to police their bodies has been argued. This takes place within a discourse which presumes that the body is modifiable to conform to current standards. Finally, it is the privilege of the powerful to have their bodies unmarked. (Cairns&Johnston2015;Coulman,et al2017;Cranwell&Seymour-Smith 2012;Donaghue&Clemitshaw2012;Johnson2018;Knutsen,etal2011a&b,2013; Maor2012,2013;McDonald,et al2007;Monaghan2005;Salant&Santry2006;Scholz

2009;Simpson2015;Throsby2007,2008,2009,2012a&b;Throsby&Gimlin2010;
Young&Burrows2013).

Chapter Seven: Conclusion

This research was done in response to the current climate of concern about an obesity crisis and the use of WLS as one part of the solution. WLS is predicated on the assumption that if you make it very difficult for a large person to eat a lot, then they will lose weight, and maintain that loss, to the improvement of their health. This 'simple obesity' is central to the debate and leads to simple solutions being offered such as traditional recommendations to eat less and exercise more – even though their failure is well-documented. WLS is unquestionably more effective than such methods in maintaining weight-loss and reducing co-morbidities, even though its effects diminish over time.

My aims were to research the experience from the viewpoint of the person undergoing surgery because the considerable psychological literature appeared to neglect this aspect. I explored how the available discourses around over-weight were being reflected in the talk of the participants and asked about any changes in the relationship with it.

In line with other researchers using DA, my analysis showed that the discourse of personal responsibility for health was evident in the talk of the interviewees. The use of Taylor & Littleton's (2006) method enabled me to highlight the role of distancing, both in time and space, in the identity work of the interviewees – ie. its 'before and after' and 'us and them' characteristics - so that the pre-surgery identity of being at the mercy of circumstances beyond their control was different from who they are at present and will continue to be in the future. Participants built an identity of someone who had put a great deal of effort into trying to lose weight prior to WLS and was therefore capable of hard work and self-discipline. This made them worthy candidates for the 'tool' of surgery. They also distanced their current identities from those of people who were still big. Talk from a position of one who has lost weight, produced an othering disparagement of those who had not maintained their weight-loss which was characteristic of fattist discourse. Dreams of transformation, and hope that past struggles with weight were over, featured strongly.

Given that WLS usually restricts a person's ability to ingest food, I asked about any changes in the relationship to food occasioned by the surgery. There was a great deal of talk about food and eating but it was almost entirely about managing the post-surgery diet and trying to avoid dumping. My analysis suggests that a pre-surgery identity of being blameless for overweight had been built and to express feelings of loss would undermine that claim. The absence of emotional talk about food is significant to me as a psychoanalytic clinician, but my chosen model of DA is not an appropriate method with which to explore this.

Most of my participants were still technically obese, but all had lost significant amounts of weight and, of those who were more than two years post-surgery, all had been able to maintain that loss. My study was limited by the lack of people for whom WLS had not 'worked' in the sense of enabling them to maintain weight lost. It would be a valuable area to research given the costs – financial and personal – of wasted surgery. As with much other qualitative research my sample of twenty people was small, but as Coulman et al (2017) point out, there is value in synthesizing the findings of small-scale studies to generate "clinically useful knowledge." (p548)

In this dissertation I have aimed to present a more complex picture of high weight, and suggested that any treatment of it needs to take this complexity into account. The possible contributory factors to massive, incapacitating weight are many and varied and have their origins in physiology, history, social structure, culture, economic conditions, and general and individual psychological factors and, as a result, I still see WLS as a simplistic response to this complex issue. If it is viewed as having deeper psychological and structural origins, then WLS cannot be effective in all cases. It is remarkably successful for some; for the majority it keeps their weight within bounds; while for a minority it is a failure.

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Appendix 1

Eating for life with a gastric band

This information leaflet should only be used from at least 6 weeks after your band placement and when you are tolerating normal textured food.

A reminder on how the band works once optimal adjustment is achieved

To have an "optimal adjustment" means that it is the most favourable adjustment that can allow you to work well and in a healthy, effective way with your band.

The band generates a background sense of satiety (satisfaction related to feeling full and not hungry) that is present 24 hours a day. This happens because the band presses on nerves in the stomach that report to the brain, therefore the overall level of hunger is lower. Secondly when you do eat the sense of satisfaction comes quickly with a smaller amount of food. This is because one bite can require up to 6 squeezes from the oesophagus (your "food pipe") to get it across the band and each squeeze generates a satisfaction signal that is sent from the nerves to the brain. In summary, you will have a lower level of hunger that can be controlled by a smaller sized meal. A meal containing about 20 bites should provide sufficient levels of satisfaction.

The gastric band is locked around the top of your stomach and secured in place with stitches. The band makes a small pouch at the top of the stomach (this is known as the "proximal pouch"). To avoid stretching the small pouch, every bite of food should completely pass through the band before you swallow another bite. The squeezing to get the food through the band takes time and can be up to a minute, even for well chewed food. This makes it very important to take your time when eating and to wait between bites of food.

Eating in the early stages when the optimal band adjustment has not yet been achieved:

Everyone is different so it may take some time to achieve the optimal level of band adjustment that will give you a reduced overall hunger level that is not causing you difficulty swallowing, regurgitation or poor eating behaviour. During this time it is very important that you maintain the healthy dietary changes that you made before your surgery to achieve your target weight, as this will help you to continue managing your weight. This is also a perfect time to continue practicing those dietary habits (outlined below) that you will need to maintain for the band to be an effective tool for weight management.

1. Eat at regular, planned times including 3 meals a day and avoid grazing
2. Eat mindfully by chewing foods well (aim for around 20 times), tasting and enjoying the flavours and textures
3. Eat slowly, leave a minute in between bites
4. Choose healthy, nutritionally balanced food and drink

When you have reached your optimal band adjustment

The optimal band adjustment is achieved when you have a lower overall level of hunger throughout the day and you feel satisfied by eating smaller sized meals.

- \- Eat 3 small regular, planned meals. Eating irregularly will increase hunger and lead to uncontrolled eating
- \- Use a small plate (for example a side plate or child's size plate) and a small spoon or fork
- \- Take your time. A normal meal should take about 20minutes (30 minutes maximum), 1 bite
  per minute. If rushed you may eat more or not chew food so well
- \- Use normal textured food (do not stick to liquid or softer foods) so that it needs several squeezes from the oesophagus to pass the band
- \- Take a small bite of food and chew it very well: Make sure everything is reduced to a mush before swallowing (there are some foods that people may have problems chewing well, please refer to the next section for information). It will help you to try and chew your mouthfuls 20 times (or as near to 20 times as possible)
- \- Once you swallow the bite, wait a minute to allow it to pass through the band
- \- Appreciate food by eating mindfully – taste the flavours and enjoy the textures
- \- Stop eating when you are no longer hungry
- \- Drink 10 minutes before meals or 30 minutes after. Liquid mixed with food may over-fill the pouch or flush food past the band too quickly reducing the satisfaction signals sent to the brain. If you really need a drink at your mealtime, think of it as a bite by leaving a minute either side of the mouthful.
- \- The need to have a snack (and how many) will depend on your overall nutritional intake, how active you are, your hunger levels and your weight management plan. Some people do not need to include regular snacks but if you do choose healthy foods, such as a piece of fruit, a small pot of light/diet yoghurt, and structure them in between meals. It is best to avoid "grazing" throughout the day as this can lead to consuming more calories than you realise and poor weight loss. For individual advice please discuss this with your dietician.
- \- Eat without distractions. Tension or excitement may make you eat too fast or you may forget to chew. However some people need a mild form of entertainment to help them leave a minute in between swallowing bites, such as a word puzzle, book or music.
- \- Continue choosing healthy, nutritious food and drinks
-

  The "20-20-20, wait a minute" rule

  Some people find it useful to remember the "20-20-20,wait a minute" rule which means the meal should last about 20 minutes, no longer than 30minutes, you should not take more than 20 small bites/mouthfuls, you

should chew each bite for 20 seconds (about 1 second per chew) and wait a minute between each swallow.

Normal textured food

Liquid and pureed food will pass across the band easily. Therefore the oesophagus will not need to squeeze them past the band and as a result the satisfaction signals from the nerve to the brain will not be generated. For this reason it is essential that you choose normal textured food and chew well.

However there are some foods that only come in the form of liquid, puree or soft texture so if you wish to have them it is advisable to include these as part of a meal

Food	How to increase satisfaction
Yoghurt	Have with some chopped up fruit.
Minced meat (in a Bolognese or chilli)	Include some vegetables such as onion, pepper, mushroom and carrot. Eat with a small jacket potato.
Fruit smoothies	Eat as the whole fruit, chopped up. Have as thick as possible with a cracker or a very small bowl or cereal.
Mashed potato	Eat with some tender cooked meat or fish and some vegetables or salad.
Soup	Choose a thicker, lumpier soup. Add some lentils, beans, tender cooked meat or vegetables.
Soft, smooth cereal such as porridge or soggy wheat biscuits, for example	Swap to a non-soggy cereal such as bran flakes or no added sugar museli.
Weetabix or a supermarkets own brand	Do not allow wheat biscuits to soak in the milk for so long. Add some chopped up fruit. Replace with a slice of toast and a boiled egg.

with normal textures. Below are some examples of this...

Problem foods and drinks

Everyone is different and so we are unable to provide clear advice on which foods you may experience difficulties with. Below is a table of potential problem foods and drinks and possible solutions.

Mango	• Small pieces, chew very well
Fizzy drink	• Avoid if the gas causes discomfort • Leave drink to go flat and choose low calorie/diet variety
Reheated food	• Add stock, water or tomato puree • Avoid dry reheated meals

Potential problem food/drink	Possible solution
White and fresh bread	• Toast until quite dry and crisp • Try melba toast • Switch to crackers • Try flat bread such as pitta • Try wholegrain breads and toast
Meat	• Slice very thinly • Marinade to tenderize • Slow cook • Use mince • Use softer protein such as eggs, beans, chick peas, lentils, fish and tofu
Octopus/squid	• Don't over cook • Choose other seafood • Try salmon or tuna
"Al dente" (cooked but with a firmer consistency) pasta	• Over cook pasta • Smaller shapes • Try noodles instead
Skins on apple, stone fruit, grapes, pears	• Slice into thin wedges • Peel fruit • Try canned fruit in natural juice
Oranges and grapefruit	• Cut each segment into bite size pieces • Avoid tough and fibrous bits
Hot chips	• Avoid
Nuts	• Chew very well
Doughy buns	• Avoid
Dry meat, for example chicken	• Switch to tender moist cuts such as tenderloins or thighs • Cook with moisture • Avoid dry cooking baking, grilling, BBQ and pan frying
Rice grains	• Try different cooking styles, for example risotto

What can happen if the above guidance is not followed?

If you continue to eat too quickly, do not chew well, have larger portions or do not leave time for the food to pass the band, over time this may lead to stretching of the small pouch of stomach above the band. The stretched pouch will reduce the effect of your band and therefore you may suffer with weight regain. It may also cause other band related complications. It is therefore highly recommended that you work with your band as outlined above.

If you are concerned about this, please contact the bariatric team to discuss it further.

Partying
Being socially active is very important for positive emotional wellbeing but be careful not to overdo it. Because you are eating only a small amount, you may be more prone to the intoxicating effects of alcohol than you used to be. Beware too of the fact that alcohol contains liquid calories and will not provide any sense of satisfaction with the band, making weight gain easier.

Exercise
To help with your weight management and overall health we recommend you aim to be active for at least 30 minutes a day for 5 times a week. To help with further weight loss we recommend you increase this and aim for 60 minutes a day for 5 days a week. As you will have done when making dietary changes, set yourself small, realistic, achievable goals to build up to your activity target.

Vitamin and mineral supplements and blood monitoring
Please refer to your vitamin and mineral supplementation and blood monitoring leaflet provided by the dietician.
As a reminder you should be taking daily supplements of a complete (A-Z) multivitamin and mineral supplement (once a day) and a calcium and vitamin D supplement (such as calcichew D3 Forte three times a day). You should arrange for your nutritional bloods to be checked 3 months after your surgery and repeated every 3 months in the first year and yearly thereafter. These are lifelong requirements to ensure you are nutritionally healthy.

Patient support group
Remember, the band is a tool and works best when you think of it as 10% surgical handiwork and 90% your hard work. You will find the patient group an invaluable resource for learning from other patients and your success will, in turn, inspire other people considering surgery. Please contact the British Obesity Surgery Patient Association (BOSPA) for more information on your local group via their website www.bospa.org.

Further dietetic support
Dieticians are available to support you in making changes to your eating habits, lifestyle and activity levels – don't hesitate to ask for help if you are struggling. We recognise that it is difficult to change these habits and that you will need long-term support.

(This is version of the PIL given to LAGB patients at Musgrove Park Hospital, Taunton as of 2014. I had to make some changes to the layout, but the content has not been altered.)

Appendix 2: CASP

10 questions to help you make sense of qualitative research

How to use this appraisal tool

Three broad issues need to be considered when appraising a qualitative study:
Are the results of the study valid? What are the results?
Will the results help locally?
(Section A) (Section B) (Section C)
The 10 questions on the following pages are designed to help you think about these issues systematically. The first two questions are screening questions and can be answered quickly. If the answer to both is "yes", it is worth proceeding with the remaining questions.
There is some degree of overlap between the questions, you are asked to record a "yes", "no" or "can't tell" to most of the questions. A number of italicised prompts are given after each question. These are designed to remind you why the question is important. Record your reasons for your answers in the spaces provided.
These checklists were designed to be used as educational pedagogic tools, as part of a workshop setting, therefore we do not suggest a scoring system. The core CASP checklists (randomised controlled trial & systematic review) were based on JAMA 'Users' guides to the medical literature 1994 (adapted from Guyatt GH, Sackett DL, and Cook DJ), and piloted with health care practitioners.
For each new checklist a group of experts were assembled to develop and pilot the checklist and the workshop format with which it would be used. Over the years overall adjustments have been made to the format, but a recent survey of checklist users reiterated that the basic format continues to be useful and appropriate.
Referencing: we recommend using the Harvard style citation, i.e.:
Critical Appraisal Skills Programme (2017). CASP (insert name of checklist i.e. Qualitative Research) Checklist.
[online] Available at: *URL*. Accessed: *Date Accessed.*
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Screening Questions

1. Was there a clear statement of the aims of the research?

HINT: Consider

- • What was the goal of the research?
- • Why it was thought important?
- • Its relevance

2. Is a qualitative methodology appropriate?

HINT: Consider

- • If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
- • Is qualitative research the right methodology for addressing the research goal?

Is it worth continuing?

Detailed questions

3. Was the research design appropriate to address the aims of the research?

HINT: Consider

• If the researcher has justified the research design
(E.g. have they discussed how they decided which method to use)?

☐ Yes ☐ Can't tell ☐ No

☐ Yes ☐ Can't tell ☐ No

☐ Yes ☐ Can't tell ☐ No

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4. Was the recruitment strategy appropriate to the aims of the research?

HINT: Consider

- • If the researcher has explained how the participants were selected
- • If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
- • If there are any discussions around recruitment (e.g. why some people chose not to take part)

5. Was the data collected in a way that addressed the research issue?

HINT: Consider

- • If the setting for data collection was justified
- • If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
- • If the researcher has justified the methods chosen
- • If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews were conducted, or did they use a topic guide)?
- • If methods were modified during the study. If so, has the researcher explained how and why?
- • If the form of data is clear (e.g. tape recordings, video material, notes etc)
- • If the researcher has discussed saturation of data

6. Has the relationship between researcher and participants been adequately considered?

HINT: Consider

- • If the researcher critically examined their own role, potential bias and influence during
(a) Formulation of the research questions
(b) Data collection, including sample recruitment and choice of location
- • How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

❑ Yes ❑ Can't tell ❑ No

❑ Yes ❑ Can't tell ❑ No

❑ Yes ❑ Can't tell ❑ No

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7. Have ethical issues been taken into consideration? ❑ Yes ❑ Can't tell ❑ No

HINT: Consider

- • If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- • If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
- • If approval has been sought from the ethics committee

8. Was the data analysis sufficiently rigorous?

HINT: Consider

- • If there is an in-depth description of the analysis process
- • If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data?
- • Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- • If sufficient data are presented to support the findings
- • To what extent contradictory data are taken into account
- • Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

❑ Yes ❑ Can't tell ❑ No

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9. Is there a clear statement of findings?

❑ Yes ❑ Can't tell ❑ No

HINT: Consider

- • If the findings are explicit
- • If there is adequate discussion of the evidence both for and against the researchers arguments
- • If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- • If the findings are discussed in relation to the original research question

10. How valuable is the research?

HINT: Consider

- • If the researcher discusses the contribution the study makes to existing knowledge or understanding e.g.

do they consider the findings in relation to current practice or policy?, or relevant research-based literature?

- • If they identify new areas where research is necessary
- • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

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Appendix 3: EPHPP

QUALITY ASSESSMENT TOOL FOR QUANTITATIVE STUDIES

COMPONENT RATINGS

1. **A) SELECTION BIAS**
    1. **(Q1) Are the individuals selected to participate in the study likely to be representative of the target population?**
        1. 1 Very likely
        2. 2 Somewhat likely
        3. 3 Not likely
        4. 4 Can't tell
    2. **(Q2) What percentage of selected individuals agreed to participate?**
        1. 1 80 - 100% agreement
        2. 2 60 – 79% agreement
        3. 3 less than 60% agreement
        4. 4 Not applicable
        5. 5 Can't tell
2. **B) STUDY DESIGN**
    Indicate the study design
    1. 1 Randomized controlled trial
    2. 2 Controlled clinical trial
    3. 3 Cohort analytic (two group pre + post)
    4. 4 Case-control
    5. 5 Cohort (one group pre + post (before and after))
    6. 6 Interrupted time series
    7. 7 Other specify ____________________________
    8. 8 Can't tell

    Was the study described as randomized? If NO, go to Component C.

No Yes

If Yes, was the method of randomization described? (See dictionary)

No Yes

If Yes, was the method appropriate? (See dictionary)

RATE THIS SECTION STRONG MODERATE WEAK	RATE THIS SECTION STRONG MODERATE WEAK
See dictionary 1 2 3	**See dictionary** 1 2 3

No Yes

1

C) CONFOUNDERS

1. **(Q1) Were there important differences between groups prior to the intervention?**
    1. 1 Yes
    2. 2 No
    3. 3 Can't tell

    The following are examples of confounders:

    4. 1 Race
    5. 2 Sex
    6. 3 Marital status/family
    7. 4 Age
    8. 5 SES (income or class)
    9. 6 Education
    10. 7 Health status
    11. 8 Pre-intervention score on outcome measure
2. **(Q2) If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)?**
    1. 1 80 – 100% (most)
    2. 2 60 – 79% (some)
    3. 3 Less than 60% (few or none)
    4. 4 Can't Tell
4. **D) BLINDING**
    1. **(Q1) Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?**
        1. 1 Yes
        2. 2 No

3. 3 Can't tell
2. **(Q2) Were the study participants aware of the research question?**
   1. 1 Yes
   2. 2 No
   3. 3 Can't tell

5. **E) DATA COLLECTION METHODS**
   1. **(Q1) Were data collection tools shown to be valid?**
      1. 1 Yes
      2. 2 No
      3. 3 Can't tell
   2. **(Q2) Were data collection tools shown to be reliable?**
      1. 1 Yes
      2. 2 No

RATE THIS SECTION STRONG MODERATE WEAK	RATE THIS SECTION STRONG MODERATE WEAK
See dictionary 1 2 3	**See dictionary** 1 2 3

3. 3 Can't tell

RATE THIS SECTION STRONG MODERATE WEAK
See dictionary 1 2 3

2

F)

WITHDRAWALS AND DROP-OUTS

1. **(Q1) Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?**
   1. 1 Yes
   2. 2 No
   3. 3 Can't tell
   4. 4 Not Applicable (i.e. one time surveys or interviews)
2. **(Q2) Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).**
   1. 1 80 -100%
   2. 2 60-79%
   3. 3 less than 60%
   4. 4 Can't tell
   5. 5 Not Applicable (i.e. Retrospective case-control)

INTERVENTION INTEGRITY

1. **(Q1) What percentage of participants received the allocated intervention or exposure of interest?**
   1. 1 80 -100%
   2. 2 60-79%
   3. 3 less than 60%
   4. 4 Can't tell
2. **(Q2) Was the consistency of the intervention measured?**

RATE THIS SECTION STRONG MODERATE WEAK
See dictionary 1 2 3 Not Applicable

G)

H)

ANALYSES

1. **(Q1) Indicate the unit of allocation (circle one)**
   community organization/institution
2. **(Q2) Indicate the unit of analysis (circle one)**
   community organization/institution

1 2 3

(Q3) Is it likely influence 4

5 6

Yes

No

Can't tell

that subjects received an unintended intervention (contamination or co-intervention) that may the results?

Yes

No

Can't tell

(Q3) Are the statistical methods appropriate for the study design?

1. 1 Yes
2. 2 No

3. 3 Can't tell

practice/office practice/office

individual individual

(Q4) Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?

1. 1 Yes
2. 2 No
3. 3 Can't tell

3

GLOBAL RATING COMPONENT RATINGS

Please transcribe the information from the gray boxes on pages 1-4 onto this page. See dictionary on how to rate this section.

A SELECTION BIAS STRONG MODERATE WEAK
123
B STUDY DESIGN STRONG MODERATE WEAK
123
C CONFOUNDERS STRONG MODERATE WEAK
123
D BLINDING STRONG MODERATE WEAK
123
E DATA COLLECTION METHOD STRONG MODERATE WEAK
123
F WITHDRAWALS AND DROPOUTS STRONG MODERATE WEAK
1 2 3 Not Applicable

GLOBAL RATING FOR THIS PAPER (circle one):

1. 1 STRONG
2. 2 MODERATE
3. 3 WEAK

With both reviewers discussing the ratings:

(no WEAK ratings)

(one WEAK rating)

(two or more WEAK ratings)

Is there a discrepancy between the two reviewers with respect to the component (A-F) ratings? No Yes

If yes, indicate the reason for the discrepancy

1. 1 Oversight
2. 2 Differences in interpretation of criteria
3. 3 Differences in interpretation of study

Final decision of both reviewers (circle one):

1 STRONG

2 MODERATE

3 WEAK

Appendix 4

Tables Summarising Papers from the Literature Review

Quantitative Studies

Title	Author/s & Date	Content	Country	EHPP Rating
Grazing and Loss of Control Related to Eating: Two High-risk Factors Following Bariatric Surgery	Colles et al (2008)	129 pre and post-operative subjects exploring eating-pattern changes and their impact on weight-loss using both standard and author-produced questionnaires.	Australia	Moderate
A Comparison of Health Professionals' and Patients' Views of the Importance of Outcomes of Bariatric Surgery.	Coulman et al (2016)	Combined systematic review of literature and interviews with patients and professionals on outcomes of WLS. Patients valued QOL outcomes more than professionals.	UK	Strong
Lay Definitions of Ideal Weight and Overweight	Crawford & Campbell (1999)	1342 subjects across weight spectrum. Lay definitions differed substantially from professional ones.	Australia	Moderate

		Women consistently defined lower ideal BMIs than did men.		
Eating Behaviour and the Experience of Hunger Following Gastric Bypass Surgery for Morbid Obesity	Delin et al (1997)	3 groups comprising 34 post-surgery; 17 pre-surgery and 30 controls. Explored relationship between weight, attitudes to food and eating, and experience of hunger, satiety and desire for food.	Australia	Moderate to Strong
Obese Patient's Perceptions of Treatment Outcomes and the Factors that Influence Them	Foster et al (2001)	397 WLS candidates' weight-loss expectations. Professional estimation of success falls below what is 'disappointing' result for patients.	USA	Strong
Weight Loss Expectations in Obese Patients and Treatment Attrition: An Observational Multicenter Study.	Grave, et al. (2005)	Multi-centre study of effect of weight-loss expectations on patient attrition. Found the higher the expectation, the more likely the attrition at 1 year.	USA	Strong
What Is My Goal? Expected Weight Loss and Co-morbidity	Karmali et al (2011)	45 surgery candidates. Patients expected improvement in co-	USA	Moderate to Strong

Outcomes Among Bariatric Surgery Patients		morbid conditions but had unrealistic weight-loss goals.		
Unrealistic Weight Loss Expectations in Candidates for Bariatric Surgery	Kaly et al (2008)	Weight-loss expectations of 284 WLS candidates. ‘Disappointing’ loss for patients equalled ‘successful’ outcome for providers.	USA	Moderate to Strong
Ten-year trends in health-related quality of life after surgical and conventional treatment for severe obesity: the SOS intervention study.	Karlsson et al (2007)	Examined effects of WLS on HRQOL over 10 years. Compared 655 WLS patients with 621 conventionally treated controls. 75% compliance. Found generally positive HRQOL outcome, but it declined over time. Ability to maintain weight-loss affected HQROL.	Sweden	Strong

Patient Motivation for Bariatric Surgery: Characteristics and Impact on Outcomes	Libeton et al (2004)	208 patients at 1 year post-surgery. Improved health main reason for choosing surgery but is not predictive of weight-loss.	USA & Australia	Moderate
Long-Term Outcomes After Bariatric Surgery: Fifteen-Year Follow-Up of Adjustable Gastric Banding and a Systematic Review of the Bariatric Surgical Literature	O'Brien et al (2013)	3,227 patients from I centre were followed up after LAGB surgery, 714 of whom had completed >10 years follow-up. Found excess weight-loss of 47% maintained at 15years. Follow-up intact for 78% beyond 10years.	USA	Strong

General practitioners' and patients' models of obesity: whose problem is it?	Ogden et al (2001)	Survey of 599 patients and 89 general practitioners. Found contradictory models of causes and treatments of obesity held by patients and doctors.	UK	Moderate
Changes in Taste Perception and Eating Behaviour After Bariatric Surgery-Induced Weight Loss in Women	Pepino (2014)	27 pre and post-WLS patients – 17 RYGB and 10 LAGB. Found in similar weight-loss there had been similar changes in eating behaviour. Not related to changes in taste-sensitivity.	Not given	Weak to Moderate
Obese patients after gastric bypass surgery have lower brain-hedonic responses to food than after gastric banding	Scholtz et al (2014)	30 RYGB, 28 BAND, 25 BMI-matched un-operated controls using fMRI, eating behaviour questionnaires and hormonal phenotyping to compare the three groups. RYGB group had lower brain-hedonic responses to food and healthier eating behaviour than BAND patients.	UK	Strong
The phenomenology of food cravings: The role of mental imagery	Tiggeman & Kemps (2005)	Study of 130 students. 'Phenomenology' not used in its philosophical sense - its meaning is equated with 'experience of' .	Australia	Moderate
Hedonic hunger is increased in severely obese patients and is reduced after gastric bypass surgery	Scultes et al (2010)	123 obese people, 136 post-surgery patients and 110 non-obese controls, using Power of Food Scale questionnaire. Obese had markedly higher hedonic hunger ratings than other groups.	Switzerland	Strong
Lifestyle, diabetes and cardiovascular risk factors 10 years after bariatric surgery.	Sjöström et al (2004)	Prospective study of 5750 patients between 2 and 10 years post-WLS. Improvement in all areas compared with controls.	Sweden	Strong

Effects of Bariatric Surgery on Mortality in Swedish Obese Subjects.	Sjöström et al (2007)	1471 subjects 1444 controls. Mean follow-up period 10.9 years. Overall mortality reduced in WLS candidates in study period. Not clear if that is case over full life-span, or what causes this.	Sweden	Strong
Understanding Patients' Value of Weight Loss and Expectations for Bariatric Surgery	Wee et al (2006)	44 prospective bariatric surgery candidates. Patients had unrealistic expectations of weight loss after surgery.	USA	Moderate
Expectations and Outcomes with Gastric Bypass Surgery	Wolfe & Terry (2006)	Survey of 194 post-operative patients, 47.99% response-rate. Satisfaction unrelated to degree of weight-loss.	USA	Weak
Initiation and Maintenance of Weight Loss after Laparoscopic Adjustable Gastric Banding. The role of Outcome Expectation and Satisfaction with the Psychosocial Outcome	Zijlstra et al (2009)	91 patients, both pre and post-operative, using the 'Obesity Psychosocial State Questionnaire' which measures seven domains. Expectations of psycho-social improvements were shown to be independent of weight loss.	Netherlands	Moderate

Critical Discussions and Reviews

Title	Author/s & Date	Content	Country	Strength
The Effectiveness and Risks of Bariatric Surgery: An Updated Systematic Review and Meta-analysis, 2003-2012.	Chang et al (2013)	Looked at mortality, complications, reoperations, weight-loss, remission of co-morbidities. Found that WLS provides sustained effects on weight-loss and ameliorates co-morbidities in majority of cases. Risks of complication, reoperation, and death exist. Death rates were lower than those reported in previous meta-analyses.	International	Searched Medline, Embase, Scopus, Current Contents, Cochrane Library, and Clinicaltrials. gov 2003-12. 164 studies included – up to 5 years post-surgery.
Grazing and Loss of Control Related to Eating: Two High-risk Factors Following Bariatric Surgery.	Colquitt et al	Updated Cochrane review to assess effects of WLS including control of co-morbidities by comparing surgical with non-surgical procedures.	International	Selected 22 RCTs assessing a range of WLS methods. Noted poor reporting of adverse events. Longest follow-up was 10 years.
Patient experiences of outcomes of bariatric surgery: a systematic review and qualitative synthesis.	Coulman et al (2017)	Review of qualitative literature. Living with results of WLS is far from straightforward. Positive feelings diminished over time – particularly after weight regain.	UK	Clear argument for synthesizing results of small-scale qualitative studies.

Alimentary epigenetics: A developmental psychobiological systems view of the perception of hunger, thirst and satiety	Harshaw (2008)	Critical discussion: Developmental model suggests that hunger, thirst and satiety are not innate but emerge out of experience during individual development. Account should be taken of behavioural, biological, perceptual and cognitive aspects of hunger and thirst.	USA	Clear outline of aims. Review of research into interoceptive awareness of hunger, thirst and satiety. Acknow-ledge that paper presents case in favour of a devel-opmental model.
Preoperative Predictors of Weight Loss Following Bariatric Surgery: Systematic Review	Livhits et al (2012)	Systematic review. Demonstrates difficulty of comparing studies because of the wide variety of measures used. Suggest pre-operative psychosocial factors that may be associated with weight loss after bariatric surgery include preoperative BMI and super-obesity, mandatory pre-surgery weight loss, and personality disorders.	International	Data bases: Pub Med; Cochrane; 534 articles. Detailed informa-tion identification and selection of papers given. Limitations noted such as possible publication bias due to preponder-ance of positive studies.

Relationships between human thirst, hunger, drinking, and feeding	McKiernan et al (2008)	Review of literature. Combined with an observational study of 50 free-living adults who recorded hourly appetitive ratings and consumption. Drinking more responsive to thirst than eating to hunger. No significant associations found between appetite and food intake.	USA	Searched life sciences lit. for "hunger, fullness, satiety, appetite, food intake, human" between 1995-2005. 39 papers. Mention publication bias. Question "validity of appetite ratings as proxy measure of intake."
Hunger Ratings are Not a Valid Proxy Measure of Reported Food Intake in Humans	Mattes (1990)	Critical discussion of research which uses hunger ratings as indicators of energy intake based on his research looking at normal rather than laboratory conditions.	USA	Highlighted problems of defining and measuring hunger & using reported hunger to indicate amount of food to be consumed - challenging much existing research.
Hunger and Thirst: Issues in Measurement and Prediction of Eating and Drinking	Mattes (2010)	Critical discussion of research into hunger and thirst, and a discussion of the complexities involved in measuring them with examples from his research using 'free-living' measures rather than laboratory	USA	Demonstrated limitations of research which relies upon "… temporal,

		simulations. Found thirst to be more motivating than hunger which has clear implications consumption of high-calorie drinks.		motivational, metabolic and/or self-reported descriptive indices" because the "associations between hunger and eating and between thirst and drinking are generally weak."
Eating for pleasure or just wanting to eat? Reconsidering sensory hedonic responses as a driver of obesity	Mela (2006)	Critical discussion of research into taste, liking, and palatability of foods as explanations of 'non-homeostatic' eating.	Netherlands	Shows simplistic physiological explanations of why people eat are inadequate. Note complex 'external' cues.
Cut down to Size: Achieving success with weight loss surgery	Radcliffe (2014)	Written as information for patients from an uncritical viewpoint.	UK	Negative aspects of WLS made clear. Changed eating dealt with, but new relation to food absent.
The Swedish Obese Subjects Study – what has been accomplished to date?	Ryden & Torgerson (2006)	Review of the findings of the SOS study to date. Paradox: weight-loss and gain increase mortality risks. Over time risk factors post-WLS relapse despite weight-loss being maintained.	Sweden	Note complexity of researching effects of WLS and emphasise need of good compliance

				rates, adequate duration, large samples, proper distribution of sexes.
Roux-en-Y gastric bypass and laparoscopic sleeve gastrectomy: understanding weight loss and improvements in type 2 diabetes after bariatric surgery.	Scott & Batterham (2011)	Mechanistic review of RYGB and sleeve gastrectomy. Conventional mechanisms do not fully explain the improvement in co-morbidities. Changes in appetite as a result of bypass, and altered hormonal, neuronal, and nutrient signalling, are the suggested cause.	UK	Written from a purely medical physiological point of view. Strongly supports WLS. Little reference made to changes over the long-term.
Review of the key results from the Swedish Obese Subjects (SOS) trial.	Sjöström (2013)	Review of key results from large scale, multi-centre RCT of WLS between 2004 and 2012. Follow-up periods of between 10 and 20 years.	Sweden	Description of the studies in the SOS: sample sizes, analysis methods, and conclusions.
The Phenomenology of Food Cravings.	Weingarten & Elston (1990)	A review of the literature of food cravings. They note that 'craving' is an hypothetical construct not a measureable phenomenon. Craving does not equal consumption.	Canada	Criticise use of lay definitions of 'craving' in scientific literature.
Gut Hormones and Appetite Control	Wren & Bloom (2007)	Review of role of gut hormones in appetite and satiety. Suggest hormone-based therapies for obesity treatment.	USA	

Qualitative Studies

Title	Author/s & Date	Content	Country	CASP
Perceived Psychosocial Outcomes of Gastric Bypass Surgery	Bocchieri et al (2002)	In-depth individual and group interviews based on grounded theory. Found numerous challenging, tension-creating, life-changes after surgery.	USA	Moderate to Strong
Monitoring and Normalising a Lack of Appetite and Weight Loss	Cranwell & Seymour-Smith (2012)	Discourse analysis of internet support group posts to examine how patients constructed their appetite, diet and weight-loss.	International	Strong
Weight regain among women after metabolic and bariatric surgery: a qualitative study in Brazil	De Carvalho et al (2014)	Psychoanalytically informed interviews exploring responses to weight regain in the years after surgery.	Brazil	Moderate
Wishing for deburdening through a sustainable control after bariatric surgery.	Engström & Forsberg (2011)	Study using Grounded Theory. Found hope for control of eating through WLS. After 2 years, fear of losing control surfaced.	Sweden	Moderate to Strong
A Qualitative Study of GP's Views of Treating Obesity	Epstein & Ogden (2005)	Study of 21 GPs using IPA. Found GPs had 'little enthusiasm for weight management'. GP – problem located in patient; patient – problem is medical.	UK	Moderate
Living with Bodily Changes after Weight Loss Surgery: Women's Experiences of Food and 'Dumping'	Groven et al (2012)	Phenomenological study with 22 people post-surgery using "conversational interviewing". Found that relating to a new body; the experience of dumping; and changes in ability to control were challenging.	Norway	Moderate

Contrasting Views of the Post-bariatric Surgery Experience between Patients and their Practitioners: a Qualitative Study	Jumbe & Meyrick (2018)	Thematic analysis of interviews:10 patients minimum of 2years post-WLS and 8 surgeons. Found discrepancies between views of patient's subsequent health needs.	UK	Moderate
Understanding the Life Experiences of Brazilian Women after Bariatric Surgery: a Qualitative Study	Magdaleno et al (2010a)	Psychoanalytically informed interviews to explore the challenge of maintaining weight loss after WLS	Brazil	Moderate
Surgical Treatment of Obesity: some considerations on the transformations of the eating impulse.	Magdaleno et al (2010b)	A psychoanalytic account of the origins of the experiences of satiety and satiation or their absence	Brazil	Moderate
Obesity Surgery: Stories of Altered Lives	Meana & Ricciardi (2008)	Popular, not academic book, based on grounded theory/thematic analysis – individual and group interviews with thirty-three people post-surgery. Deliberately avoided topic of hunger.	USA	n/a
An Evaluation by Focus Group of the Patient's Experiences of the Weight Management Service at Musgrove Park Hospital, Taunton	Moreland (2014)	Open focus group discussion about the pre-surgery preparation provided by the weight management service in which the participants talked more about their surprise at continuing to feel hungry and about the foods they wanted to eat.	UK	Weak to Moderate
Consumer views of hunger and fullness. A qualitative approach	Murray & Vickers (2009)	Focus groups of obese, normal weight dieters, and non-dieters to discuss hunger and fullness. Concluded that the complexity of those concepts has been underestimated.	USA	Moderate to Strong

Re-embodying Eating: Patients' Experiences 5 Years After Bariatric Surgery	Natvik et al (2014)	Study of fourteen subjects five years after surgery using phenomenological methods. Eating remained problematic post-surgery.	Norway	Moderate to Strong
Exploring the Impact of Obesity Surgery on Patients' Health Status: a Quantitative and Qualitative Study	Ogden et al (2005)	Questionnaire to 22 post, and 39 pre-surgery patients as controls. In-depth interviews with 15 of the former. Health improvement and changed relationship to food found.	UK	Moderate to Strong
The impact of obesity surgery and the paradox of control: A qualitative study	Ogden et al (2006)	15 post surgery patients who thought cause of their obesity was external and out of their control, but surgery gave them feeling of control. Stress importance of individual variation in experience.	UK	Moderate to Strong
Internet Marketing of Bariatric Surgery: Contemporary Trends in the Medicalization of Obesity	Salant & Santry (2006)	Multi-method systematic content analysis of 100 bariatric surgery websites which draw upon contradictory discourses of medicalization claiming 'external' causes of obesity to justify surgical intervention while surgical failure is due to individual behaviour.	USA	Strong
At What Cost?: Problematising the Achievement of 'Health' through Thinness – The Case of Bariatric Surgery	Simpson (2015)	Research conducted with a WLS support group looking at self-surveillance and policing of weight and the, sometimes harmful, means by which this is achieved.	New Zealand	Weak to Moderate
Long-Term Quality of Life Following Bariatric Surgery: A Descriptive Study	Stolzenberger et al (2013)	Discuss meaning of quality of life for WLS patients over the long-term. 61 participants took part in focus groups. Detailed description of methods used.	USA	Moderate to Strong

‘How could you let yourself get like that?’: Stories of the origins of obesity in accounts of weight loss surgery	Throsby (2009)	Discourse analysis describing the failure of standard treatments to sustain weight loss; the moral emphasis placed on losing weight; and how people protect themselves against accusations of moral laxity by choosing WLS.	UK	Moderate to Strong
Happy Re-birthday: Weight-Loss Surgery and the ‘New Me’	Throsby (2012a)	Discourse analysis - WLS does not cure over-weight or type II diabetes in all cases. Irony of still being obese yet no longer seen as needing treatment.	UK	Strong
‘I’d kill anyone who tried to take my band away’: Obesity Surgery, Critical Fat Politics and the ‘Problem’ of Patient Demand.	Throsby (2012b)	Discourse analysis using material gathered from people who have undergone WLS, she argues against Fat Activist blanket repudiation of WLS – it denies the lived experience of such people	UK	Strong

Appendix 5

Information Sheet for Participants in Research Interviews to Explore the Experience of Bariatric Surgery

Researcher: Janet Moreland who is a doctoral research student at Exeter University.
Date: February 2016
Version: 2

This information sheet is to help you decide whether you want to take part in the research. Please think about it and feel free to discuss it with your family or friends. I am happy to answer any questions you might have.

Thank you for taking the trouble to read this.

What is the purpose of the research?
There is very little information in the academic literature about what it's like, from the *patient's* point of view, to undergo bariatric surgery and to live with its results. I'd like you to tell me about your experience of the surgery in the hope that what I learn from you can be useful to weight management services, and to other people who are thinking of having surgery. It is also part of a Doctorate in Clinical Practice that I am undertaking at the University of Exeter.

Do I have to take part?
No you don't, and you can withdraw at any time without giving a reason.

What will happen in the interview?
We will meet for up to an hour to talk about what it was like to go through the surgery and what life has been like since then. I am particularly interested in knowing what has happened to your desire to eat – is it what you expected?
I will sound-record the discussion which I will make a written copy of. I won't use your real names, and I will disguise anything you say that could identify you.

Are there any disadvantages to taking part?
You will be giving me the time you spend talking with me.

Will it cost me anything?
No.

What are the possible benefits?
It will be a chance to talk about the experience of the surgery and of what you've learnt. You may also have the good feeling that you are helping the people who come after you to get the best possible service.

Who will know I'm taking part?
Only those people you choose to tell.

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Will everything I say be kept confidential?
I will be the only person who listens to the tape, which I will encrypt and keep safely in a locked filing cabinet. The tape and the written transcript will be kept separately.

What will happen to the results?
I will analyse what is said to find the main things you talk about and I will write a paper describing them. You can read this if you wish, but I will in any case send you a summary of it.

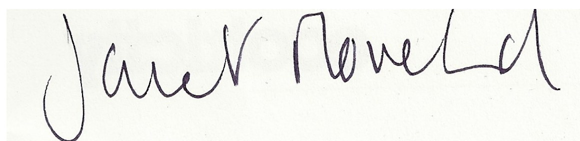
Who is organising and funding the research?
I am.

Who has reviewed this study?
The University of Exeter Psychology Research Ethics Committee

If I have any complaints about the study, who can I contact?
Research supervisor, Dr Jean Knox, Department of Psychology, University of Exeter.
E-mail: J.M.Knox@exeter.ac.uk

Who do I contact for further information?
Janet Moreland - researcher e-mail: jem237@exeter.ac.uk
Phone: 01392-496193
Text only: 0770-960-8683

Thank you for thinking about taking part,



Janet Moreland
Psychology
College of Life and Environmental Sciences
University of Exeter
Washington Singer Building
Perry Road
Exeter EX4 4QG

Pg.2

Appendix 6

Gee, JP (1999) *Discourse Analysis: Theory and Method*. London: Routledge

(pp 110-111)

1. "What are the situated meanings of some of the words and phrases that seem important in the situation?
2. What situated meanings and values seem to be attached to places, times, bodies, people, objects, artifacts, and institutions relevant in this situation?
3. What situated meanings and values are attached to other oral …quoted or alluded to in the situation? (intertextuality)
4. What Discourse models seem to be at play in connecting and integrating these situated meanings to each other?
5. What institutions and/or Discourses are being (re)produced in this situation and how are they being stabilized or transformed in the act?"

Appendix 7

Your application for ethical approval (2016/1089) has been accepted
apache@exeter.ac.uk
on behalf of
Ethics Approval System <D.M.Salway@exeter.ac.uk>
Tue 15/12/2015, 17:00Moreland, Janet

Ethical Approval system

Your application (2016/1089) entitled Patient expectations and experience of bariatric surgery - with particular reference to the experience of hunger and the desire to eat. has been accepted
Please visit http://www.exeter.ac.uk/staff/ethicalapproval/
Please click on the link above and select the relevant application from the list.

Appendix 8

Consent Form for Participants in Research to Explore Experiences of Bariatric Surgery

Researcher: Janet Moreland
E-mail: jem237@exeter.ac.uk
Version: 1
Date: December 2015

(Please initial each box)

I have read and understood the information sheet (dated February 2016) telling me about the research.	☐
I can choose not to take part in the research and I can leave at any time without giving a reason.	☐
I understand that the transcription of the interview may be looked at by individuals from the University of Exeter where it is relevant to my taking part in this research.	☐
I agree to take part in this research	☐

…………………………………… ……… ……………………………..

NAME OF PARTICIPANT DATE SIGNATURE

Janet Moreland
…………………………….. ……… ……………………………………

NAME OF RESEARCHER DATE SIGNATURE

This copy is for you to keep. I will have another one, for my records, which I will ask you to sign when we meet.

Thank you.

Appendix 9: Dissemination Statement

- A summary of the findings to be given to the participants.
- A paper to be offered to a WLS journal describing the patients' experiences of living with the surgery with particular reference to their apparent blindness to the probability of some weight-regain and to the perceived role of medical staff in promoting that. This paper could be circulated to weight management services.
- A paper to be prepared for a psychoanalytic journal on the significance of the concrete nature of talk about food and eating in people of high weights and incorporating a discussion of the counter-transferential responses to this.

Appendix 10

Five Criteria for Reviewing and Writing Papers

Richardson, L. (2000) "Evaluating Ethnography." *Qualitative Inquiry,* **6**:2 (pp253-255)

1. "Substantive contribution: Does this piece contribute to our understanding of social-life? Does the writer demonstrate a deeply grounded (if embedded) human-world understanding and perspective? How has this perspective informed the construction of the text?
2. Aesthetic merit: Does this piece succeed aesthetically? Does the use of creative analytical practices open up the text, invite interpretive responses? Is the text artistically shaped, satisfying, complex, and not boring?
3. Reflexivity: How did the author come to write this text? How was the information gathered? Ethical issues? How has the author's subjectivity been both a producer and a product of this text? Is there adequate self-awareness and self-exposure for the reader to make judgments about the point of view? Do authors hold themselves accountable to the standards of knowing and telling of the people they have studied?
4. Impact: Does this affect me? emotionally? intellectually? generate new questions? move me to write? move me to try new research practices? move me to action?
5. Expresses a reality: Does this text embody a fleshed out, embodied sense of lived-experience? Does it seem "true"—a credible account of a cultural, social, individual, or communal sense of the "real"?" (p254)